PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

AND THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

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Public Laws: 102nd Congress / 1st Session / House Hearings / 1991

CONTENTS

Page

Press releases announcing the hearing 2

WITNESSES

American College of Radiology, James M. Moorefield, M.D 54
American Lithotripsy Society, Hal K. Mardis, M.D 171
American Physical Therapy Association, Marilyn Moffat 101
Consumer Federation of America, Mark N. Cooper 145
Health Images, Inc., Robert D. Carl III 62
Independent Private Practitioners of Physical Therapy, Larry Shauf 137
Isikoff, Michael B., M.D., Parrish Medical Center 60
Memphis Business Group on Health, Donna Miller 82
Mitchell, Jean M., Florida State University 10
Radiation Care, Inc., Thomas L. Mills and Edward N. Hughes, M.D 161
Schwade, James G., M.D., University of Miami School of Medicine 86
Scott, Elton, Florida State University 10

SUBMISSIONS FOR THE RECORD

Alliance for Affordable Health Care, Jere W. Glover, statement and attachment 180
American Academy of Neurology, statement 197
American Imaging Association, Wayne L. Wampler, statement and attachment 202
American Physical Therapy Association, Private Practice Section, statement 219
American Society of Internal Medicine, statement 222
American Urological Association, Inc., Jay Y. Gillenwater, M.D., letter 227
National Association of Medical Equipment Suppliers, Corrine Parver, statement 229
National Association of Rehabilitation Agencies, Robert Zigenfus, statement 231
Renal Physicians Association, statement 234

PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

THURSDAY, OCTOBER 17, 1991

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
and Subcommittee on Oversight,
Washington, D.C.

The subcommittees met, pursuant to notice, at 10:20 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark (chairman of the Subcommittee on Health) and Hon. J.J. Pickle (chairman of the Subcommittee on Oversight) presiding.

[Press releases announcing the hearing follow:]

FOR IMMEDIATE RELEASE
FRIDAY, AUGUST 16, 1991

PRESS RELEASE #19
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND THE HONORABLE J. J. PICKLE (D., TEX.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCE A HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, and the Honorable J. J. Pickle (D., Tex.), Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, announced today that the Subcommittees will hold a joint hearing on physician ownership/referral arrangements. The hearing will be held on Monday, September 16, 1991, beginning at 1:00 p.m., in room B-318 Rayburn House Office Building.

The hearing will include testimony from the authors of the study conducted by the Florida Health Care Cost Containment Board, as well as from providers adversely affected by physician ownership/referral arrangements. Proponents of such arrangements have also been invited to present testimony. The hearing will focus on the effect of these arrangements on access to, and utilization of, health services and on the effectiveness of current laws in preventing abusive arrangements.

Oral testimony will be heard from invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing.

BACKGROUND

The Social Security Amendments of 1972 established penalties for any person furnishing Medicare or Medicaid services who solicited, offered, or received any kickbacks or bribes related to the provision of those services or rebate of any fee or charge for referrals of business payable under Medicare or Medicaid.

The Medicare and Medicaid Anti-Fraud and Abuse Amendments of 1977 established criminal penalties for soliciting, receiving, offering, or giving, directly or indirectly, any remuneration (including kickbacks, bribes, or rebates) in return for referrals of a health care item or service payable under Medicare or Medicaid.

The Medicare and Medicaid Patient and Program Protection Act of 1987 authorized the Inspector General of the U.S. Department of Health and Human Services to impose civil monetary penalties and to exclude from Federal health care programs persons who violated the anti-kickback statute. The 1987 law also required the Inspector General to issue the so-called "safe harbor regulations," which identify practices which will *not* be treated as violations of the anti-kickback law. These regulations were issued on July 29, 1991.

Congress took further action on ownership/referral arrangements in 1989. In that year, the Inspector General issued a report in May titled, "Financial Arrangements Between Physicians and Health Care Businesses." The report found that patients of referring physicians who own or invest in independent clinical laboratories received 45 percent more clinical laboratory services than all Medicare patients in general.

(MORE)

The Inspector General's findings were similar to those of a study conducted by the U.S. General Accounting Office (GAO) and reported to the Subcommittee in testimony on June 1, 1989.

Enacted as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), section 1877 of the Social Security Act bans, with certain specified exceptions, referrals to clinical laboratories with which the referring physician has a financial relationship.

The legislation also required the Health Care Financing Administration (HCFA) to collect information comparing utilization of services by entities in which a referring physician has a financial interest with the utilization of such services by other entities. HCFA is currently preparing to survey physicians in ten states in order to respond to this requirement. A GAO study is also required by OBRA '89 and will be completed once the survey data are collected by HCFA.

In 1989, the Florida legislature directed the Florida Health Care Cost Containment Board to conduct a study of ownership or compensation arrangements between persons and facilities providing health care. The study was conducted by researchers at Florida State University under contract to the Board. Volume II of the study, released in draft August 9, 1991, analyzes the prevalence, scope, and nature of joint ventures among health care providers.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Those who wish to file a written statement for the printed record of the hearing must submit six (6) copies by the close of business on Monday, September 30, 1991, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. Statements must contain the name and capacity in which the witness will appear or, for written comments, the name and capacity of the person submitting the statement, as well as any clients or persons, or any organization for whom the witness appears or for whom the statement is submitted.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

* * * * *

* * * NOTICE -- CHANGE IN SCHEDULE * * *

FOR IMMEDIATE RELEASE
THURSDAY, SEPTEMBER 12, 1991

PRESS RELEASE #19-REVISED
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND THE HONORABLE J. J. PICKLE (D., TEX.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCE POSTPONEMENT OF THE HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, and the Honorable J. J. Pickle (D., Tex.), Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, announced today that the joint hearing on physician ownership/referral arrangements, scheduled for Monday, September 16, 1991, has been postponed. The hearing will be rescheduled and a press release issued with the new date and time.

* * * * *

FOR IMMEDIATE RELEASE
WEDNESDAY, SEPTEMBER 18, 1991

PRESS RELEASE #21
SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
1114 LONGWORTH HOUSE OFFICE BLDG.
WASHINGTON, D.C. 20515
TELEPHONE: (202) 225-7785

THE HONORABLE PETE STARK (D., CALIF.), CHAIRMAN, SUBCOMMITTEE ON HEALTH, AND THE HONORABLE J. J. PICKLE (D., TEX.), CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCE THE RESCHEDULING OF THE HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

The Honorable Pete Stark (D., Calif.), Chairman, Subcommittee on Health, and the Honorable J. J. Pickle (D., Tex.), Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, announced today that the joint hearing on physician ownership/referral arrangements, originally scheduled for Monday, September 16, 1991, has been **rescheduled for Thursday, October 17, 1991, beginning at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building.**

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Those who wish to file a written statement for the printed record of the hearing must submit six (6) copies by the close of business on Thursday, October 31, 1991, to Robert J. Leonard, Chief Counsel and Staff Director, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements may be furnished for distribution to the press and public if supplied to the Subcommittee office, 1114 Longworth House Office Building, before the hearing begins.

All other details for the hearing remain the same. (See press releases #19 and #19-Revised, dated Friday, August 16, and Thursday, September 12, 1991.)

* * * * *

Chairman STARK. The hearing will come to order.

Today, the Subcommittee on Health and the Subcommittee on Oversight of the Committee on Ways and Means will jointly hear testimony regarding issues relating to physician ownership/referral arrangements.

This is an issue with which our committee has been grappling for some time. In the Omnibus Budget Reconciliation Act of 1989, based on data reported by the Inspector General of the Department of Health and Human Services and the General Accounting Office, the Congress banned Medicare referrals to clinical laboratories with which a referring physician has a financial relationship. That law goes into effect January 1, 1992.

At the time we wrote the law, it was decided to focus on clinical laboratories, or, if you will, ignore the other physician-owned facilities, because reports before us clearly supported the contention that ownership by referring physicians led to significantly higher use of laboratory services and greatly higher costs to Medicare.

Unfortunately, at that time similar data on other services were not available to the committee.

Since then, several studies were started to analyze the impact of referral arrangements on utilization and on costs to Medicare and to the health care system at large. Today, we will hear the results of one such study conducted by the Florida Health Care Cost Containment Board.

Not surprisingly, the Florida study will support our contentions—physician ownership/referral arrangements cost all of us money.

Studies have shown that as many as 25 percent of the procedures provided to patients in this country are not needed. Unfortunately, one of the reasons some physicians perform unnecessary procedures is that they earn a higher profit as a result. This is particularly true in the case of physicians who invest in facilities to which they can refer patients for specialty care, and I used the word "invest" advisedly, because these investments generally do not follow any normal definition of investment.

The issue comes down to one major point, and that is whether or not you believe that turning a physician's decision to refer a patient into a marketable commodity is good medicine, good economics, and good government. In this case, the Chair does not.

Physician ownership/referral arrangements represent an exploding virus which ultimately will erode the trust that patients have traditionally placed in their physicians. The sad thing is that we are quickly getting to the point where each of us is going to have to wonder if we are getting a service because we need it, or because it would increase our physician's dividend check.

In the end, this issue will be decided by the analysis which is currently under way. I predict each of these studies will demonstrate that physician ownership/referral arrangements drive up utilization and the cost of health care.

I continue to believe that all referrals to a facility by physicians with an ownership interest should be banned, and I look forward to working toward that goal with my colleagues.

I would like at this point to review for my colleagues and our guests the genesis of the original law. This Subcommittee on

Health has never been legislatively concerned with ethics nor, indeed, with the quality of medical care, at least insofar as it ought to be determined by the professional groups and licensing boards.

There was a law in 1976, which is still on the books, which says that it is a $50,000 fine or 5 years in the Federal penitentiary if a physician takes a referral fee, directly or indirectly, for referring directly or indirectly any patient to another service or facility or provider in Medicare. This is not illegal if it is not a Medicare patient. It is a matter of indifference to the Chair what the ethics of this practice are or are not. It is the law.

Most of the joint ventures which have come to the attention of this committee would not pass the sniff test as being a legitimate investment venture. They are plainly and simply, to anyone who can read or count to 10 with their shoes and socks on, a way to funnel referral fees or split fees for procedures.

There is no economic necessity, because the equipment is readily available under normal financing channels, and in most of these ventures the physician investor is denied the opportunity or forbidden to participate in the business or professional side of the venture, so you cannot say they have any more control. These ventures are simply a way around the 1976 law.

I have suggested to organized medicine representatives that if we do not intend to obey this law and if lawyers and accountants keep dreaming up schemes around it, then perhaps we ought to repeal the 1976 law, at which point it would be up to the Physician Payment Review Commission to institutionalize fee splitting and referrals. Then let us put it on the table and let the physicians decide which percentage of which radiologist's fee will be shared by the pediatrician or the general practitioner or the internist, and we will let PhysPRC and HCFA and ultimately Congress review the fees and set them. That would have no objection from the Chair, and we would, therefore, be able to control the costs, which is the ultimate issue that we have here, and physicians could determine on a resource based relative value scale who ought to share in these fees.

That seems to me to be the opposite of what the 1976 law intends, but it would work effectively and satisfy the legislative responsibility that is set in this committee. I want to say that, because you will hear a lot of testimony today about ethics, competitiveness, and free enterprise, and I will stipulate to the importance of all of those things.

But the issue I am concerned with is how do these various ventures conform to the 1976 law, and, in fact, when that law is violated, does it harm the taxpayers or the patients? I am sorry for that little extra interjection, but I wanted to set the record straight insofar as the Health Subcommittee's interest in this.

The other major legislative leader who has a vital interest in this issue is my distinguished colleague from Texas, Mr. Pickle, who chairs the Subcommittee on Oversight, whose responsibility is to make sure that, once we pass these complicated dreaded laws, that we see that they are enforced and carried out, and I am honored to recognize the distinguished gentleman from Texas.

Chairman PICKLE. Well, I thank you, Mr. Chairman.

The Oversight Subcommittee is pleased to join with you in this joint hearing today. I might say at the beginning that I approach the subject with a slightly different view than the distinguished chairman from California does, but we share the same general concern about overutilization.

During the 101st Congress, the Subcommittees on Health and Oversight held two hearings on issues relating to physician "self-referrals." The term "self-referral" is used to describe the referral by a physician of a patient, for testing or treatment, to an ancillary health care facility outside the physician's office and independent of his own practice, but in which the physician has a financial interest.

In my view, there is nothing wrong with self-referral per se. It takes place all the time. Lawyers refer clients to title companies that they own, or to lobbying firms in which they hold an interest. Businessmen routinely refer people to firms that they own.

In the context of medicine, however, self-referrals give rise to concern, because of the potential influence that they may exert on physicians' judgment in ordering tests or therapy. The concern, then, is not entirely one of ownership, but, rather, of the possible overutilization of ancillary medical services.

In a day and age of skyrocketing medical costs, the Federal Government cannot afford to be spending Medicare and Medicaid money for procedures that are not necessary. On the other hand, I have been reluctant to single out the medical profession and deny them the opportunity to make investments in facilities. It seems logical for any professional to invest in a business venture about which, by training and experience, he has acquired some degree of knowledge and expertise.

Before we consider denying doctors the opportunity to devote their resources to investments they believe are most prudent, I want to be positive that self-referrals pose a substantial risk of abuse that cannot be deterred in any other way. I am concerned that many ancillary services might not be available if physicians were not allowed to invest in them. On the other hand, I do not think—and this especially pertains to doctors—that they should be reaping undue profits from unnecessary medical tests.

So, today's hearing will focus primarily on a study by the State of Florida Health Care Cost Containment Board on the impact on access, utilization, costs, charges, and quality of health care services of "joint ventures." This is a broad report, of broad scope, addressing a wide variety and types of medical facilities.

It is the first report of its kind. It is of special interest, because of the large population of Medicare beneficiaries in Florida, and because Florida has been identified as one of the States with a relatively high rate of physician investment in ancillary medical facilities. This study will be useful as Congress continues to grapple with this problem.

I look forward to the report and I hope we can find some course that we can chart that would allow for these kinds of investments, but would safeguard against overutilization.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Schulze.

Mr. SCHULZE. Thank you, Mr. Chairman.

I would like to thank both you and Chairman Pickle for calling this hearing on physician ownership and referral arrangements. The main purpose of this hearing is to hear from representatives of the Florida Health Care Cost Containment Board, on their recent report on this topic.

In addition, we will receive testimony from physicians involved in ownership arrangements, groups seeking stronger ownership restrictions, and affected businesses.

Just as the laws of chemistry, physics, and biology govern the medical profession, so do the laws of economics. The law of human nature is such that people tend to act in their own self-interest. This rings doubly true in the case of physician self-referral. If you are a physician who makes a large number of referrals to specialized facilities like an MRI or CAT scan, it only makes sense to want to capture as much of that business for yourself as possible. Likewise, if you are in a specialty business that is always on the receiving end of physician referrals, like radiology or surgery, it only makes sense that you will want to keep others out of your market.

While the motives of self-referral are easy to understand, the actual bottom-line effects of these practices on health care recipients have not been well documented. Perhaps there are cases where patients are actually better off when physicians have an ownership interest in referral facilities. My view, however, is that many ownership arrangements are open to abuse.

The key is to identify where the abuse occurs. That is why the findings of the Florida Health Care Cost Containment Board are worthy of our attention today. For the first time, a comprehensive study is available to begin to pinpoint the problem. The study looked at the scope and nature of joint ventures among health care providers, as well as the impact on costs, access, utilization, and quality of care. They found clear evidence that problems exist with physician-owned clinical laboratories, diagnostic imaging centers, and with physical therapy centers, and called attention to other potential problem areas.

The report also addresses the durable medical equipment industry. While it was inconclusive about some of the effects of physician ownership, it did find questionable practices. For example, the report reveals the practice of doctor-owned shell corporations, which have arrangements to obtain and resell DME from actual operating DME companies, and the excess markups are then split between the physician owners and the DME companies.

The Oversight Subcommittee has also investigated abusive marketing practice in the DME industry, and recently held hearings. We found widespread abuses by unscrupulous telemarketers, and because of this, I have today introduced legislation to outlaw telemarketing of DME under Medicare.

The Oversight Subcommittee, under the leadership of Chairman Pickle, will soon report our complete findings and recommendations on DME. And Chairman Stark, while we work together to get to the bottom of physician ownership abuses, I urge you and Chairman Pickle and others to join me in eliminating DME telemarketing abuses.

I commend both chairmen for holding this hearing, and I look forward to the testimony of today's witnesses.

Chairman STARK. I thank the distinguished gentleman.

Are there other members who have opening statements?

[No response.]

Chairman STARK. If not, I would like to welcome our first panel. Our witnesses on this panel are the authors of the Florida study: Dr. Jean Mitchell, who is an associate professor of economics at Florida State University, and Dr. Elton Scott, who is an associate professor of finance.

We are pleased to have both of you here, and the reputation of your work has preceded you. We are anxious to have you tell us about your study and what it determines, and I hope you will proceed to enlighten us in any manner that you are comfortable. You may read your prepared statement, which, in any event, without objection, will appear in the record in its entirety, or you may summarize it or expand on it in any manner you are comfortable.

Who was planning to go first? Dr. Mitchell, please proceed.

STATEMENT OF JEAN M. MITCHELL, PH.D., ASSOCIATE PROFESSOR OF ECONOMICS, AND ELTON SCOTT, PH.D., ASSOCIATE PROFESSOR OF FINANCE, FLORIDA STATE UNIVERSITY

Ms. MITCHELL. Chairman Stark, Chairman Pickle, members of the Subcommittees on Health and Oversight, ladies and gentlemen:

My name is Dr. Jean Mitchell——

Chairman STARK. May I interrupt just at the beginning, as an admonition to all witnesses: We do not get to invest in microphone companies; therefore, these old microphones are not very effective unless you practically swallow them, so if you will pull them up real close, it will be easier for the reporter and our guests and the members to hear your testimony.

Thank you.

Ms. MITCHELL. Chairman Stark, Chairman Pickle, members of the Subcommittees on Health and Oversight, ladies and gentlemen:

My name is Dr. Jean Mitchell. I am an associate professor in the Department of Economics at Florida State University. I am here today with my colleague, Dr. Elton Scott, who is an associate professor in the Department of Finance at Florida State University, to present to you the findings of the study that we conducted examining the prevalence, scope and impact of joint ventures among health care providers.

We are pleased to have the opportunity to make this presentation to you. I will report the findings on prevalence and scope of joint ventures, and Dr. Scott will report the results of the impact analyses.

We are just reporting results today. There is no policy position here from the Health Care Cost Containment Board.

This study was mandated by the Florida Legislature during the 1989 session. We were contracted by the Florida Health Care Cost Containment Board to conduct the study. In our study, the term "joint venture" is defined to mean any ownership, investment interest, or compensation arrangement between physicians—or any health care professional who is in a position to make referrals—and an entity providing health care goods or services.

We developed surveys to obtain ownership, financial and utilization information from free standing Florida health care businesses. We sent out over 3,000 surveys to nine different facility types. The types of facilities we surveyed were ambulatory surgical facilities, clinical laboratories, diagnostic imaging centers, durable medical equipment suppliers, home health agencies, hospitals, nursing homes, physical therapy and rehabilitation facilities, and radiation therapy centers.

This was a mandatory survey. We sent out three mailings. Each mailing was accompanied by a letter indicating to the business that the survey was mandatory and that they could be fined for noncompliance.

We did not survey some types of health care businesses where joint venture arrangements are likely to exist. This was because of limited funding and the type of services provided and the number of providers. In particular, we did not look at lithotripsy, home infusion therapy companies, diet centers, pharmacies, kidney dialysis, or substance abuse treatment centers.

We also conducted an extensive telephone followup survey to obtain missing data and correct inconsistent responses that were reported on the survey. In addition, we did followup surveys of nonrespondents, as well as parent corporation surveys and surveys of professional association owners.

Our final overall response rate was 82.4 percent. We obtained data from approximately 2,200 facilities out of 2,700. The only group with a response rate of under 70 percent was durable medical equipment suppliers. The response rate there was 66 percent. Many of the respondent groups had response rates in excess of 90 percent.

We found that most of our nonrespondents were concentrated in the southeast peninsula region of Florida, that is, the Miami-Fort Lauderdale area.

In addition, our telephone followup of nonrespondents in ambulatory surgery, diagnostic imaging, equipment and physical therapy indicated that nonresponding facilities were much more likely to be involved in joint ventures, so the results we report to you today are conservative estimates as to the impact and scope and prevalence of joint ventures in Florida.

We discovered in doing this survey that it was difficult to identify the owners of health care businesses in Florida. If the facility is set up such that it is a limited partnership with a general partner, then these ownership arrangements can be readily identified.

On the other hand, oftentimes these ownership arrangements are masked through corporations. For example, one physical therapy rehabilitation facility sent us back their survey indicating that they had 12 limited partners and 3 health care entity owners. One of these health care entity owners was a publicly traded corporation. Another was a corporation which had 175 physician investors. The third entity owner was a corporation which had 10 physician investors.

If you look at the end of our testimony, we have described two very complex ownership arrangements—this is exhibits A and B—

which actually exist in Florida. I am not going to describe ownership exhibit A in detail, because it would take too much time, but I will describe ownership structure B, in exhibit B. If you turn to the end of your packet, you can see that.

MD Associates is a joint venture partnership. This partnership has investment interests in four health care facilities in Florida, an ambulatory surgical facility, a clinical laboratory, a diagnostic imaging center, and a durable medical equipment supplier. This joint venture partnership is, in turn, owned by two more corporations, HCSURG, Inc. and VMM Services. VMM Services is, in turn, this corporation is owned by 200 more corporations, where the single shareholder of each of those corporations is a physician.

We uncovered a number of these different ownership arrangements in the State of Florida, which made us realize that it was very difficult to identify the individual owners of these health care facilities.

We identified over 10,000 health care professional and health care entity owners. These include both the direct owners of these facilities, as well as the ultimate controlling owners through parent corporations. Over 81 percent of these owners were physicians.

More than 21 percent of the approximately 8,100 physician owners that we identified were identified through parent corporations. The majority of these physician owners, approximately 41 percent, had investment interests in diagnostic imaging facilities, another 16 percent had investment interests in clinical laboratories, whereas, another 13 percent had investment interests in home health agencies.

It was interesting: We asked for information on the specialties of these individual owners, and only 9 percent of these individual physician owners were what we classified as consultation or nonreferring physicians, that is, anesthesiologists, pathologists, and radiologists. The other 91 percent of the physician owners were concentrated in specialties that were likely to refer their patients to these facilities for tests or other ancillary services.

If you look at the end of the testimony, table 1 characterizes total physician owners by specialty and investment choice. The general pattern that emerges here is that the physician owners of these facilities, once again, are concentrated in specialties that are in a position to make referrals to the businesses they have an investment interest in.

Let me just cite one example: If you look at clinical laboratories, pathologist owners account for only approximately 6 percent of the total physician owners of clinical laboratories.

From our telephone followup of nonrespondents, as well as our surveys of professional associations, we identified approximately 9,700 physician owners in the State of Florida. These are not unduplicated counts, as you can tell from our diagrams of complex ownership structures, that some physicians have investments in more than one facility.

We estimate that there are approximately 8,500 individual unduplicated physician owners in the State of Florida for the facilities that we surveyed. Of these approximately 7,600, are physicians who are in a position to make referrals to the facility they have an investment interest in, that is, we have excluded the anesthesiologists, pathologists, and radiologists.

The American Medical Association collects data annually on physicians who are involved in direct patient care. Their results from 1989, which our findings are for 1989, indicate that during that year there were approximately 18,250 physicians involved in direct patient care practicing in Florida. Thus, we estimate that at least 40 percent of the physicians involved in direct patient care in the State of Florida have investment interests in health care facilities to which they may refer their patients for services.

Please remember that this is a conservative estimate. It does not include information on nonresponding facility owners, and it also does not include information on those types of facilities that we did not survey, where we are aware that joint venture or physician ownership is prevalent, that is, lithotripsy, home infusion, diet centers, substance abuse treatment centers.

If you look at table 2 at the end of the testimony, we have described the scope and nature of the ownership of health care facilities in Florida. The basic pattern that emerges from table 2 is that physician ownership of health care businesses in Florida that provide diagnostic testing or ancillary services is pervasive. More than three-fourths of the ambulatory surgical facilities, nearly all of the diagnostic imaging, approximately 60 percent of the clinical labs are owned by physicians.

In contrast, physician ownership of hospitals and nursing homes is much less common. Only 5 percent of the hospitals in the State of Florida were owned in whole or in part by referring physicians.

Proponents of joint ventures contend that these arrangements increase geographic access to persons in medically underserved or rural areas. This does not appear to be the case in Florida, however, as none of the joint venture businesses were located in medically underserved or rural areas.

Furthermore, with the exception of a few hospitals and nursing homes, none of the nonjoint venture businesses were located in medically underserved or rural areas, either. This was not surprising to us, however, because it is unlikely that the facilities which locate in medically underserved or rural areas could generate the volume of patients to break even.

I will now turn to my colleague, Dr. Scott, who will report on the impacts of joint ventures on access, utilization, costs, and charges of health care facilities in Florida.

Mr. Scott. Good morning.

I would like to talk about the measures that we used to evaluate the impact on access, utilization, costs, charges of facilities where the ownership involves a physician who is in a position to make referrals or another health care professional who is in a position to make referrals.

The measures of access focused on access to poor persons, that is, charity, uncompensated care, as well as Medicaid services. In addition, we evaluated the impact on access to Medicare patients. We also looked at utilization by measuring the number of services per patient, and looked at charges, either charges per patient or charges per procedure for the two types of facilities.

In addition, the issue of profits has been mentioned in the opening statements, and while we in our system should expect profits, normal and reasonable profits are necessary to keep people investing their funds in a business that provides a service that is needed. But to the extent that profits are excessive, particularly in health care, these profits must be generated by either unusual levels of efficiency in providing the service, or must be provided by charging more for the service than is warranted, than is competitive, or by producing the service at a lower cost than your competitors, either by efficiency, as I mentioned, or by providing product that is not of the same quality as your competition.

So, to the extent that we look at a group of businesses, if there is consistent, systematically greater levels of profitability, we would have to conclude that those businesses are either systematically more efficient or that they are charging more for the service, either in the form of excess utilization or charges, or that they are producing a product that has less quality to it than do the services of their competitors.

The idea also of using profits to measure the impact of joint ventures also addresses the issue of the impact of joint ventures on competition. In healthy competition, joint venture businesses should yield about the same profit level as a nonjoint venture business.

In our study, the only distinction—well, except that we subgrouped businesses by the kind of service provided, so that the operating results would be comparable, otherwise, and after subgrouping them we then divided them into businesses that had physicians or other health care professionals making referrals to the business, and those that did not have such owners, that had no such physician ownership.

Based on comparisons of these groups, we found that—and the basic premise we tested was that joint venture businesses have no effect or have a beneficial effect for consumers of health care services. So, if the evidence was not strong that there was a deleterious effect, we did not reject that hypothesis. This sort of gives the benefit of doubt to the joint venture businesses, and only when the results were statistically significant, at the point one level, did we decide that this was a strong enough indication of a problem.

Our results indicated that there appear to be no deleterious effects in hospitals or nursing homes, and in fact joint venture ownership may have even a beneficial effect in a nursing home case.

The results on four other kinds of facilities, ambulatory surgical facilities, durable medical equipment suppliers, home health agencies, and radiation therapy centers, were inconclusive. These results were inconclusive, in part, because some of these facilities have such small numbers that we could not get statistically significant differences. In other cases, there would be some measure that indicated a potential problem, but not a clear and consistent pattern of significant differences in the measures we employed.

The ambulatory surgical facilities had some indications of there being access problems, that is, less services being provided to poor persons. The durable medical equipment suppliers, again, there was some indication of access differences. And while there was no statistical test of this issue, we found reports or we obtained reports in collecting the data that shell corporations had been set up in this particular industry between a physician owner and an existing supplier of durable medical equipment supplies.

These shell corporations are problematic, in that if you assumed the supplier of the equipment has normal markup on the equipment, which is, in turn, marked up again by this shell corporation that has no employees and owns no assets of the kind used in the business, this would simply inflate the charge to the consumer.

Again, while we did not provide statistical test of this, there was evidence in the surveys returned of companies that reported 100 percent of their expenses to be contract expenses, indicating no real employees or no actual employees, and that all services were provided to them under contract to some actual supplier of the durable medical equipment.

The home health agencies indicated there might be differences in utilization, but there was no clear pattern there.

Radiation therapy, we had a small sample, and there were further problems with measuring the revenues and profits in this group, and we reached no conclusion on the impact of joint ventures of radiation therapy services.

We found clear indications of problems for clinical laboratories, physical therapy facilities, and diagnostic imaging centers. If you will refer to the last page of our testimony, the last page summarizes the areas where we found statistically significant indications of negative effects of joint ventures on the provision of health care services.

Clinical laboratories results indicated that they provided significantly lower percentages of services to poor persons, that is, charity or uncompensated care, and Medicaid patients.

There is a blank for Medicare, meaning that it was not statistically significant when we compared the percentages for Medicare. Utilization was significantly higher for the joint venture laboratories, and charges were significantly higher. The profitability measures, again, were not statistically significantly different.

I should mention that we subdivided clinical laboratories into those that provided a broader range of services and those that were more limited in the scope of services provided, to control for differences that would occur due to a different nature of those businesses.

With physical therapy services, we found that, except for the measures of access to poor persons, there were statistically significant indications of differences, systematic differences for joint venture business, with significantly lower access to Medicare patients, significantly higher utilization, significantly higher charges, and significantly higher profits.

Here again, we subdivided physical therapy centers into two types, those that were more limited in scope and those that provided comprehensive rehabilitation services.

We also evaluated for physical therapy services a quality measure. Quality was a difficult problem and, in general, we did not reach any conclusions on quality differences. But for physical therapy services, we found that joint venture physical therapy centers and rehabilitation centers employed statistically significantly fewer licensed physical therapists per patient than did the nonjoint venture physical therapy services.

Based on this, you must conclude that the nonjoint venture businesses provided either longer visits with licensed practitioners or that the services being provided at the nonjoint venture businesses were more complex. That is, the joint ventures tended to either have simpler procedures or tended to not use licensed physical therapists when delivering physical therapy services.

Diagnostic imaging centers were problematic, in that very few diagnostic imaging centers in Florida are not joint ventured. Almost all diagnostic imaging centers in Florida are joint ventured. As Dr. Mitchell reported, the predominant choice of physicians for investment is in diagnostic imaging centers. Over 3,000 physicians in Florida were reported as owners of diagnostic imaging centers.

The comparison, because there was no nonjoint venture comparison group in Florida, is limited, and, therefore, the statement "low" in the first two categories, access to poor persons and access to Medicare recipients, is not a statistical statement, this does not indicate statistically significantly lower percentages, but, rather, compared to other kinds of health care businesses, these imaging centers tended to provide less services to the groups identified there.

We compared utilization for these centers by looking at the utilization patterns for three Florida MSAs that had characteristics that were similar to the characteristics of the Baltimore MSA, where we were able to obtain data, and where only one joint venture imaging center was operating in 1989.

This comparison, using the Baltimore MSA as a comparison, we evaluated also the major causes of hospitalization, to be sure that we did not have a systematic difference in terms of the kinds of illnesses that were prevalent in that city, compared to our choices in Florida, where Jacksonville, Orlando, and Miami were the MSAs that surround those cities, and in each case the pattern of illnesses were similar, the morbidity or the rates of mortality for the leading causes of death were very similar, and the proportion of elderly persons residing in these MSAs were similar.

In addition, the median income for Baltimore was higher, while costs of living were not significantly different or were not different relative to the income level.

So, as best we could, this represented a reasonable comparison base, and in each case we compared the utilization of CAT scans or outpatient CAT scans and outpatient MRI scans of patients, and in every case, the number of services per 1,000 persons living in these areas was higher for the Florida MSAs, where almost all of the businesses are joint ventures. In fact, all but one of the businesses are joint ventures in Florida.

The charges were not compared, but profits were compared to other facility types. They were not compared as joint venture versus nonjoint venture imaging centers, because there was not such a comparison available to us. Profits were measured as the average percent operating margin on the revenues that were generated.

So, after deducting direct expenses, but not fixed expenses, we called this number the operating profit and we divided it by the net revenues that were generated to produce the income. That percent was then compared across each facility type; to see how much variation there was in this income.

In finance, this is a reasonable way to measure businesses that are fundamentally different. It is a way to compare apples and oranges, if you will, because the average income is a measure of the reward that an investor receives, and the variability of the income is a measure of the risk of investing in that business.

So, if we divide a measure of the rewards by the measure of risk, we get a reward to risk ratio, and the reward to risk ratio for the four sort of high-tech imaging centers, MRIs, CAT scans, comprehensive centers, and those with other high-tech imaging services, mammography and other ultrasonic-type equipment, this reward to risk measure was significantly higher than were reward to risk measures for all of the other health care businesses in Florida regardless of whether they were joint ventures.

The measure that we used there was statistically significant and was tested using methods that were not sensitive to the assumptions that you make about the data.

This result and the results on the physical therapy facilities indicate also that, where joint ventures predominate, the profits tend to be larger for the joint ventured businesses.

This summarizes the results of our study, and we are happy, either Dr. Mitchell or myself are happy to answer your questions.

[The prepared statements and attachments follows:]

JOINT VENTURES AMONG HEALTH CARE PROVIDERS IN FLORIDA

STATEMENT OF: Jean M. Mitchell, Ph.D., Associate Professor of Economics, Florida State University AND Elton Scott, Ph.D., Associate Professor of Finance, Florida State Univeristy

BEFORE THE SUBCOMMITTEES ON HEALTH AND OVERSIGHT
COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES
HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS
OCTOBER 17, 1991

Chairman Stark, Chairman Pickle, Members of the Subcommittees on Health and Oversight, ladies and gentlemen:

My name is Dr. Jean M. Mitchell. I am an associate professor in the Department of Economics at Florida State University. I am here today with my colleague Dr. Elton Scott, who is an associate professor in the Department of Finance at Florida State University, to present the findings of the study we conducted examining the prevalence, scope, and impacts of joint ventures among health care providers in Florida. We are pleased to have this opportunity to make this presentation. I will report the findings on prevalence and scope and Dr. Scott will report the results of the impact analyses.

The study was mandated by the Florida Legislature, under Chapter 89-354, Section 6, Laws of Florida. We were contracted under an intergovernmental contract between Florida State University and the Health Care Cost Containment Board to conduct the study. The term "joint venture" has been specified to mean any ownership, investment interest or compensation arrangement between physicians (or any health care professional who may make referrals), and an entity providing health care goods or services. All results and conclusions are from Volumes I and II of "Joint Ventures Among Health Care Providers in Florida". These reports can be obtained from the Florida Health Care Cost Containment Board.

Overview of the Survey Process

Surveys were developed to obtain ownership, financial and utilization data from Florida health care providers regarding the 1989 fiscal year. Surveys were mailed to over 3000 freestanding entities; the types of facilities surveyed were ambulatory surgical facilities, clinical laboratories, diagnostic imaging centers, durable medical equipment suppliers, home health agencies, hospitals, mental health treatment centers, nursing homes, physical therapy and rehabilitation centers, and radiation therapy centers. The technical aspects of the data collection were handled by the Survey Research Laboratory at Florida State University. The survey process required three mailings staged over a three-month period. The cover letter that accompanied each survey form indicated that all facilities were required under a legislative mandate to comply. The letter also indicated that the Board had the authority to impose civil penalties for noncompliance.

Some types of health care providers where joint venture arrangements exist were considered but not ultimately surveyed due to limited funding, the number of facilities involved, and the range of services provided. The provider groups considered but not surveyed are: pharmacies, home infusion therapy services, lithotripsy services, kidney dialysis centers, diet centers, substance abuse treatment centers, orthotics/prosthetics businesses, and adult congregate living facilities.

Subsequently, followup surveys of nonrespondents, surveys of parent corporation owners, and surveys of professional association owners were conducted. A significant effort of telephone followup calls were conducted to obtain missing data and to correct inconsistent information reported on the facility questionnaires.

The final overall response rate is 82.4 percent; 2,200 of the 2,669 eligible facilities submitted a survey with usable and consistent information to classify each facility as joint venture or nonjoint venture. More than 90 percent of the ambulatory surgical facilities, hospitals, nursing homes, and psychiatric hospitals filed completed surveys. The response rates for clinical laboratories, mental health treatment centers, physical therapy and/or rehabilitation centers, home health agencies, diagnostic imaging centers and radiation therapy centers range between 72 and 85 percent. Only durable medical equipment suppliers had a response rate under 70 percent. The majority of the nonrespondents are concentrated in the Southeast peninsula region; about 26 percent (190) of the 713 facilities in this geographic region failed to file a completed survey.

The telephone followup of nonresponding facilities indicates that the nonrespondents are more likely to be involved in joint venture arrangements. Furthermore, the telephone followup identified several facilities that failed to respond because they were ineligible.

The Structure of Joint Venture Arrangements

Identifying the individual owners of entities providing health care services is a difficult task because sometimes the ownership structure is very complex. If the facility is owned directly by a partnership with a number of limited partners and a general partner, then these individual owners can be readily identified. On the other hand, the ownership structure of a health care business may be masked if the facility is owned directly by one or more corporations, but the individual indirect owners of the corporations are physicians. For example, one health care business in Florida reported three health care entity owners and several individual limited partners; each limited partner is a physician. One of the health care entity owners is a publicly traded corporation, while the other two are privately held companies. One of the privately held companies is owned by 175 physicians while the other is owned by ten physicians.

An even more complicated situation arises when the ownership structure is masked through several layers of corporations or partnerships. These setups make it extremely difficult to identify the individual owners of the ultimate parent organization. In exhibits A and B we describe two examples of joint ventures that exist among health care providers in Florida to provide some insights as to the complexity of these arrangements. While the names used for the organizations in these examples have been changed, the structure of the existing ownership arrangements is described accurately.

The ownership structure of Case A is illustrated in exhibit A. Three paths of ownership arrangements can be traced to JMM MEDICAL CARE, INC., a not-for-profit corporation, with approximately 100 physicians on the board of directors. First, JMM MEDICAL CARE, INC. is the parent corporation of JMM FOUNDATION, a not-for-profit hospital, which operates under the name FHB HOSPITAL.

The second ownership arrangement involving JMM MEDICAL CARE, INC. is more complex. JMM MEDICAL CARE, INC. and a corporation with approximately 100 physician investors, known as DOCS INC., jointly own a for-profit entity called MD HEALTH CARE CORPORATION. Many of the physician owners of DOCS INC. serve as directors of JMM MEDICAL CARE, INC. The structure of the joint venture becomes even more complicated because MD HEALTH CARE CORPORATION in turn owns four health care providers: CAT SCANS INC., HOME HEALTH SERVICES INC., DURABLE MEDICAL EQUIPMENT INC., and MRI CENTER, LTD. Each of these health care entities is a for-profit corporation.

The third ownership path is also a complex arrangement. The not-for-profit company (JMM MEDICAL CARE, INC.) owns a for-profit holding company known as JMM HOLDING COMPANY, INC. This holding company in turn owns three for-profit businesses: a home health agency (HOME CARE, INC.), a management company (MD MANAGEMENT SERVICES, INC.) and a third corporation known as HOSPITAL CARE, INC. The ownership path continues as HOSPITAL CARE, INC. is the general partner in a joint venture with ES GENERAL LIMITED PARTNER INVESTORS. Together, this general partner and these limited partners jointly own MD HOSPITAL, a for-profit institution which operates under an alternative name, ES GENERAL HOSPITAL. Furthermore, although not apparent from the chart presented in exhibit A, several of the limited partner shares of ES GENERAL are owned by DOCS INC. -- the corporation which has over one hundred physician investors.

A second example highlighting the complexity of joint venture arrangements among health care providers is presented in exhibit B. The corporation MD ASSOCIATES owns four health care entities that provide services in Florida: an ambulatory surgical facility (AMSURG, INC.), a clinical laboratory (LAB TEST, INC.), a diagnostic imaging center (IMAGING, INC.) and a durable medical equipment business (MEDICAL EQUIPMENT, INC.). MD ASSOCIATES is a joint venture between two corporations: HCSURG, INC. and VMM SERVICES, INC. While the ownership structure of HCSURG, INC. remains to be determined, VMM SERVICES has over 200 individual corporate owners. Each of these individual corporations has a single stockholder who is a physician.

These examples illustrate the problems encountered in determining the ultimate beneficial owners of subsidiary health care facilities. Failure to recognize the complexity of some joint ventures and subsequently obtain data on the owners of the ultimate parent organization will lead an understatement of the prevalence and scope of joint venture arrangements. These examples clearly illustrate that ownership can be disguised in ingenious ways.

Characteristics of Physician Owners

The facility surveys identified 10,001 health care professional and health care entity owners. These include both the direct owners of these facilities as well as owners through a parent organization. More than 81 percent (8,112) of these owners are physicians. Over 21 percent or 1,723 physicians were identified as indirect owners of health care facilities through parent corporations.

The majority of these physician owners, over 41 percent, have an investment interest in a diagnostic imaging facility. Another 16 percent of the physician owners have invested in clinical labs, while 13 percent have an ownership interest in a home health agency. Eight percent of these 8,112 physicians have ownership in an ambulatory surgical facility, while another seven percent have a financial interest in a durable medical equipment business. Six percent own part of an acute care hospital. Another six percent have invested in physical therapy and/or rehabilitation facilities. About three percent have an ownership interest in either a nursing home or a radiation therapy facility.

Only nine percent of these physician owners are in specialties that provide services on a consultation basis (pathology, anesthesiology, and radiology). These specialists are generally not in a position to make referrals to their own facility. The other 91 percent of the 8,112 physician owners are concentrated in specialties which are likely to refer their patients for surgery, diagnostic testing, and other ancillary services or equipment. The majority of these physician owners, nearly 35 percent, are internal medicine specialists. General practioners account for 11.4 percent of physician investors, while surgeons and orthopedists each represent about eight percent of the 8,112 physician owners.

Table 1 characterizes total physician owners by specialty and investment choice. The general pattern that emerges is that physician owners of these facilities are concentrated in specialties that are in a position to refer their patients to these facilities for services.

The telephone followup results for nonresponding facilities identified at least another 1,000 physician investors. The physician professional associations account for at least 570 individual owners. Thus, altogether more than 9,682 physicians have been identified as owners of health care facilities in Florida. Since some of these physicians have an investment interest in more than one health care facility, it is estimated that there are at least 8,500 unduplicated individual physician owners. Of these 8,500 physicians, 858 were pathologists, anethesiologists, and radiologists (who provide services on a consultation basis) resulting in an estimated 7,600 individual referring physician owners who are involved in direct patient care.

According to data for 1989 collected by the American Medical Association, there are approximately 18,250 physicians involved in direct patient care in Florida. Hence, these estimated 7,600 individual referring physician owners represent more than 40 percent of the 18,250 physicians involved in direct patient care in Florida.

This 40 percent figure represents a conservative or lower bound estimate as to the proportion of direct patient care physicians who are owners of joint venture businesses to which they may refer their patients for services for at least three reasons. First, the 40 percent estimate excludes physician owners of all nonresponding facilities except imaging centers. Second, some of the responding facilities failed to identify direct physician owners or indirect physician owners through a parent corporation. Third, the 40 percent excludes physician owners of health care provider types not surveyed, for example, pharmacies, lithotripsy, home infusion companies and kidney dialysis services.

The Scope and Nature of Joint Ventures

Table 2 describes the scope and nature of the ownership of health care facilities that filed completed questionnaires. These results are based on both direct ownership and on the ultimate owners through parent corporations. The details regarding the individual owners of some health care facilities is missing because some facilities refused to report the ultimate owners of their organization. For example, the legal counsel representing the joint venture partnership described in exhibit B indicated to us that his client would not disclose the names of the 200 individual physician owners of this partnership. This information, however, was accounted for in the ownership classification of facilities.

The results in Table 2 show that physician ownership of health care businesses providing diagnostic testing or other ancillary services is pervasive in Florida. More than three-fourths of the responding ambulatory surgical facilities and about 93 percent of the diagnostic imaging centers are owned either wholly or in part by physicians. Almost 80 percent of the responding radiation therapy centers, more than 60 percent of the responding clinical laboratories and nearly 40 percent of the responding physical therapy and/or rehabilitation facilities also report physician owners. Furthermore, about 20 percent of the responding durable medical equipment businesses, as well as close to 13 percent of the home health agencies are owned by physicians.

In contrast, physician ownership of hospitals and nursing homes is less common. Only 5.3 percent (12 of 227) acute care hospitals and 12 percent (54 of 450) of the nursing homes have physician owners. Psychiatric hospitals and mental health treatment centers reported no joint venture arrangements so that impact analyses were not conducted for these two types of entities.

Proponents contend that joint ventures increase geographic access to services and new technological procedures to persons residing in rural, medically underserved areas. This does not appear to be the case in Florida, however, as none of the joint venture facilities are located in rural areas. Furthermore, with the exception of some hospitals and nursing homes, few of the nonjoint venture businesses are located in less densely populated regions. The concentration of all types of health care facilities in urbanized areas is not surprising, however, because it is unlikely that less urbanized areas could generate the volume of patients necessary to achieve a breakeven point for the business.

The Impact of Joint Ventures on Utilization, Access and Costs

Our analysis evaluates the impact of joint ventures on access, costs, charges, and utilization. The measures employed and the reasons for choosing these measures are described below.

Objective measures of economic access used for our study are the percent of revenues obtained from the various payer classes. If joint ventures increase (or at least do not reduce) economic access, higher (or equal) percentages of revenues should be found for Medicare, Medicaid, and bad debt and charity care. Conversely, if economic access is reduced by joint venture ownership arrangements, these percentages would be lower for joint venture providers. In this circumstance, care for indigent patients and Medicaid patients would usually have to be obtained from outpatient units of hospitals. As a consequence, this shifts the expense of care for these patients to hospitals.

Discounts and contractual adjustments in percentage terms, are defined as gross revenues minus bad debt and charity care minus net revenues (before expenses) divided by gross revenues. Given similar list prices, the discount rate should increase as access is provided to patients at lower prices or as discounts are offered to managed care insurers.

The impact of joint ventures on "costs" can be measured from two perspectives. First, costs to consumers can be measured by evaluating gross and net charges per unit of service, adjusted by the utilization rates and controlling for the type of facility and geographic region. Second, the costs of producing units of service can be analyzed to identify potential efficiencies or inefficiencies in production.

Expenses are classified as direct or fixed; direct expenses vary directly with the quantity of services produced, whereas fixed expenses are independent of volume and decline with increased production. More efficient producers can generate more units of service per hour of employee time and thus incur lower direct expenses per unit while maintaining quality standards. Alternatively, higher levels of output can be achieved by producing at substandard quality levels. Fixed expenses include lease and rental payments, depreciation, and other overhead expense that do not vary with production levels.

In situations where normal economic forces of competition are constrained (or do not apply), businesses with market power may set prices at excessive levels or limit costs by reducing quality and thereby earn abnormally high profits. Since this situation is likely to occur with joint venture businesses we evaluate firm profitability. Profits are determined by the quantity and charges of services provided, as well as production costs. Profits represent a return to owners on their invested capital. Such returns should be large enough to compensate the owners for the risks associated with their investments. Although skillful management or luck may yield above average profits, average rates of return for a group of businesses should be comparable to the rates of return for other firms with similar degrees of risk.

Profits equal net revenues minus expenses. Operating income is generally defined as net revenues less direct operating expenses. Profits before interest and taxes equals operating profits less fixed expenses. Net profits before taxes exclude interest paid.

Operating income is used as the basis for measuring firm profitability in our study. To adjust for differences in facility size, operating income is expressed relative to net revenues. This measure is referred to as "operating income as a percent of net revenue." The measure is not adjusted for fixed expenses, interest or other overhead, because these items are sometimes influenced by joint venture arrangements.

The basic hypothesis of interest is that there are no differences (or that differences are beneficial to consumers) in average values for joint venture and nonjoint venture facilities. The alternative hypothesis assumes that differences in averages are detrimental to Florida consumers. In these comparisons, we have controlled for obvious systematic influences such as the type of service provided and geographic factors. Statistically significant differences indicate that at the 10 percent level there is some systematic influence that produced differences in the averages.

The comparisons of joint venture and nonjoint venture facilities enabled us to classify each facility group into one of three categories:

1) joint venture ownership arrangements had little or no impact on access, costs, charges, or utilization of health care services for

- acute care hospitals
- nursing homes

2) results indicated that there could be problems or the results did not allow clear conclusions on access, costs, charges, or utilization of health care services for

- ambulatory surgical centers
- durable medical equipment suppliers
- home health agencies
- radiation therapy centers.

3) joint venture ownership had negative impacts on either access, costs, charges, or utilization (or in more than one of these areas) of health care services for

- clinical laboratories
- diagnostic imaging
- physical therapy - rehabilitation centers.

First, we report the details of the findings for the three problematic areas: clinical laboratories, diagnostic imaging facilities and physical therapy-rehabilitation facilities. Following this, we summarize the findings for the four facility types we classify as potentially problematic or inconclusive due to limitations of the data collected. Hospitals and nursing homes will not be discussed because joint venture ownership has little impact on the provision of services by these facility types.

Clinical Laboratories were subdivided into four groups; effects of joint venture ownership were evaluated in detail for the two basic types of clinical laboratories: 1) labs with courier services, and 2) labs without courier services. Furthermore, some limited comparisons were also made between these labs and labs owned by pathologists. (Specialty labs were not included in the analyses.)

In terms of access, nonjoint venture courier service labs render significantly more services to Medicare and Medicaid patients than their nonjoint venture counterparts. Courier service labs owned by referring physicians, on the other hand, writeoff a larger percentage of their gross revenues as bad debt and/or charity care. Comparisons between labs without courier services show that nonjoint venture facilities generate significantly more of their revenues from Medicaid than otherwise similar labs owned by physicians. Joint venture labs without courier services, however, perform substantially more testing for self-pay patients.

Physician owned labs have significantly higher utilization rates and significantly higher revenue per patient than labs without physician owners. Courier service clinical labs owned by referring physicians perform almost twice as many diagnostic tests per patient treated as similar nonjoint venture labs perform. The number of tests per patient is 3.3 in physician owned labs compared to 1.7 in their nonjoint venture counterparts. Joint venture and nonjoint venture labs with courier services generate approximately the same amount of revenue per procedure. The higher utilization of the joint venture labs, however, results in higher gross revenues per patient. The gross revenue is about $38 for courier service joint venture labs which is significantly higher than the $20 for their nonjoint venture counterparts.

Among clinical labs without courier services, joint venture facilities perform significantly more tests per patient (2.8 versus 2.0 tests). Joint venture labs without courier service charge less per procedure than their nonjoint venture counterparts ($13.61 versus $16.52), but generate more revenue per patient ($36.30 versus $30.78) than otherwise similar labs without physician owners.

Average production costs per procedure are significantly lower in courier service nonjoint venture labs than in similar labs owned by referring physicians. The cost differential is due to facility size and economies of scale in production. For clinical labs without courier services, there is only a negligible difference in average per unit production costs. Finally, the results on scope of services suggest that nonjoint ventured clinical labs offer a broader scope of services than labs owned by referring physicians.

Diagnostic Imaging Centers reported that physicians had ownership interests in all but eleven of the responding freestanding imaging centers. Ten of the eleven nonjoint venture imaging centers provide only x-ray services. A similar pattern emerges among the nonresponding imaging centers; all but two of the nonrespondents that perform MRIs and/or CAT scans are owned by referring physicians. These results preclude meaningful comparisons of results for joint venture and nonjoint venture Florida imaging centers.

Descriptive statistics are reported for specialized and for comprehensive imaging centers. Access is a problem regardless of the type of services provided. Joint venture diagnostic imaging facilities treat a negligible number of Medicaid patients. In comparison, nonjoint venture acute care hospitals in Florida generate approximately six percent of their revenues from services rendered to Medicaid patients.

The results show that all types of imaging centers (except x-ray services centers) have higher average percent operating income (relative to the risk of that income) than the other facilities examined in this study. This higher percent operating income indicates either disproportionately high net charges or low expenses as a percent of net charges and shows that joint venture imaging centers in Florida are far more profitable than most other types of nonjoint venture Florida health care businesses.

Utilization rates are summarized MRIs and CAT scans in Florida counties with joint ventures but utilization comparisons were a problem for imaging centers due to a lack of nonjoint venture facilities in Florida. (Note that most MRI scans are performed in joint venture freestanding diagnostic centers and not in hospital outpatient radiology departments.) To overcome this problem, comparisons were made between utilization rates for the Baltimore MSA and utilization rates for three Florida MSA's with similar socioeconomic status characteristics; the Florida MSAs are Jacksonville, Orlando, and Miami.

Baltimore was chosen as the comparison MSA for at least four reasons. First, during the period of analysis there was only one freestanding MRI center in Baltimore owned by referring physicians. Second, the Baltimore MSA is relatively isolated so that the likelihood that individuals residing in surburban Baltimore will cross market borders to receive diagnostic services is small. Third, there are two major teaching hospitals located in Baltimore so that any bias in utilization should be towards higher utilization of MRI or CAT scan procedures than in a similar area without two medical schools. Finally, the populations in all four MSAs have a similar proportion of elderly, similar per capita income, and a similar incidence of the most common diseases.

These comparisons indicate that the utilization of outpatient MRI scans and CAT scans in the Florida MSAs are substantially higher than the utilization rate of outpatient MRIs and CAT scans in Baltimore. The extent of higher utilization of MRIs in the Florida MSAs relative to Baltimore ranged from 14 to 65 percent. The relative percentage differences between the utilization rates for CAT scans in each of the Florida MSAs and the Baltimore MSA ranged from five to 28 percent. The chances that these results would occur when there is no systematic difference in utilization rates are less than one in fifty.

Thus, the limited comparisons afforded by the Florida joint venture diagnostic imaging centers provide indications of excessive charges and higher utilization for imaging services.

Physical Therapy-Rehabilitation Centers were classified by type of service: 1) physical therapy services only, and 2) comprehensive rehabilitation facilities providing physical therapy, occupational therapy, speech pathology, and in some cases work hardening. Both types of joint venture facilities receive more than 60 percent of their referrals from physician owners.

Nonjoint venture facilities specializing in the provision of physical therapy services receive significantly higher percentages of their revenues from Medicare and Blue Cross/commercial insurers, and writeoff more bad debt/charity care than their joint venture counterparts. Joint venture providers, on the other hand, generate significantly more of their revenue from workers compensation patients.

Nonjoint venture rehabilitation facilities generate significantly more of their revenues from Medicare and self-pay patients in comparison to facilities owned by physicians. On the other hand, joint venture rehabilitation centers treat no Medicaid patients, and they generate significantly more revenue from Blue Cross and commercial insurers and from managed care patients than their nonjoint venture counterparts.

The findings for facilities specializing in physical therapy show that the mean number of visits per patient is significantly higher (16 in joint venture facilities compared to 11.2 for the nonjoint venture centers). Thus, patients treated at physician owned facilities receive 43 percent (4.8) more visits per patient than patients treated at nonjoint venture physical therapy centers.

Joint venture physical therapy facilities average significantly less revenue per visit but generate significantly more revenue per patient. Joint venture facilities average 31 percent or $200 more revenue per patient due to the higher utilization of services. Joint venture physical therapy facilities are also significantly more profitable than their nonjoint venture counterparts.

Joint venture physical therapy facilities provide on average 62 percent (almost 2,000) more visits per FTE licensed physical therapist; this difference is statistically significant. Physician owned physical therapy facilities also render about 40 percent more visits per FTE physical therapy worker (licensed physical therapist and licensed therapist assistants). These findings indicate that joint venture facilities either provide a lower quality of care or provide simpler services because both licensed therapy workers and nonlicensed workers spend less time with each patient. These results also explain why the average total cost of a physical therapy visit is less in joint venture facilities than in nonjoint venture facilities.

Patients treated at physician owned comprehensive rehabilitation facilities average 32 percent more physical therapy visits than patients treated at nonjoint venture facilities; this difference is statistically significant. The mean number is 13.8 visits for the joint venture versus 10.5 for the nonjoint venture.

Nonjoint venture rehabilitation facilities receive significantly more revenue per physical therapy visit, however, the average visit is longer than in joint venture facilities. The higher utilization of physical therapy visits per patient which characterizes joint venture facilities results in ten percent ($82) more revenue per patient.

Physician owned rehabilitation facilities are more profitable and have a lower average cost per visit than nonjoint venture providers. Joint venture rehabilitation facilities render about 42 percent more visits per licensed physical therapist than nonjoint venture facilities. The average number of annual visits per FTE licensed medical worker (physical therapists and therapist assistants) is 51 percent higher in joint venture facilities relative to nonjoint venture facilities. These findings imply that nonjoint venture facilities provide higher quality services because these visits are of longer duration than the average visit in joint venture facilities, or, alternatively, that services are not administered by licensed practioners.

Ambulatory surgery centers were subdivided into multispecialty surgery centers and ophthalmic specialty surgery centers. Multispecialty ambulatory surgery facilities are relatively homogenous with respect to costs, charges, and profitability. The major significant difference between joint venture and nonjoint venture multispecialty surgery facilities arises with respect to access. In particular, joint venture multispecialty surgical facilities treat no Medicaid patients. Nonjoint venture multispecialty ambulatory surgery centers also have significantly higher discounts and contractual adjustment rates than physician owned multispecialty surgery centers.

Ambulatory surgery centers specializing in eye surgery are relatively homogenous with respect to access, costs, charges, utilization and profitability. Nonjoint venture facilities have higher list charges and gross revenues per patient, but these centers also have higher average discounts that appear to offset their higher average charges. These results, however, represent small sample sizes; further study is needed for definitive conclusions.

Durable Medical Equipment Suppliers are diverse in the services provided: this diversity precludes an indepth analysis of the impact of joint ventures on this industry. Meaningful per unit comparisons of utilization, expense, and charge measures cannot be computed. Results reported are limited to the issues of access, profitability and net charges (after discounts).

Nonjoint venture equipment dealers generate a significantly larger share of their revenues from Medicare, and self-pay patients than their joint venture counterparts. This suggests that the nonjoint venture equipment dealers provide greater access to patients with limited ability to pay. Also, nonjoint venture businesses average significantly higher discounts and writeoffs than physician owned firms. If gross charges are similar, this finding suggests that nonjoint venture providers are less expensive than joint venture businesses. Finally, equipment businesses owned by physicians are significantly more profitable than nonjoint venture firms. These findings suggest that joint venture equipment dealers have relatively higher charges than their nonjoint venture counterparts.

A problematic arrangement in the medical equipment and supply industry that may inhibit competition are joint venture businesses that are "shell" companies. The "shell" company owns none of the durable medical equipment and thus assumes no risk. Rather, the risks are assumed by an ongoing business; such an arrangement can generate profits by marking up services and equipment that are provided by the operating company. The profits from this arrangement are split by the physician owners of the "shell" corporation and the operating company. More comprehensive data is needed to evaluate impacts of joint venture ownership on the utilization and expenses for durable medical equipment services.

Home Health Agencies were subdivided into agencies that are Medicare certified and those that are not Medicare certified. The joint venture agencies, while demonstrating some differences, provide no clear pattern of greater profitability from the operation of home health services. Private non-Medicare joint venture agencies generate significantly higher gross and net revenue per patient than their nonjoint venture counterparts. Medicare certified joint venture agencies render significantly more visits per patient than otherwise similar nonjoint venture Medicare agencies. The significantly higher utilization that characterizes joint venture Medicare home health agencies occurs because these agencies provide relatively lower cost, lower skilled services to their patients. The average gross revenue as well as net revenue per patient are higher for the Medicare joint venture home health agencies.

These results are based on relatively large home health agencies and do not include smaller agencies or agencies that generate a substantial part of the revenues from sources other than home health services. Moreover, joint ventures account for a small percentage of these larger dedicated home health agencies.

These results do not indicate the impact of joint ventures on the provision of home infusion therpay services. While physician ownership of home infusion therapy has been recognized as an area of concern, the data collected could not be used to evaluate the impact of joint ventures on the provision of these services.

Radiation Therapy Centers are predominately owned by physicians. Some of these facilities are owned solely by consultation or nonreferring physicians, whereas the remainder have some referring physician owners. This factor in conjunction with the small number of freestanding facilities providing these services allow only a limited analysis as to the impact of joint venture ownership.

Nonjoint venture radiation therapy facilities and joint venture facilities generate comparable shares of their revenue from all payer classes. Nonjoint venture radiation therapy centers render more procedures per patient than physician owned facilities. On the other hand, joint venture radiation therapy centers charge more per procedure, which on net results in higher total charges per patient.

Summary--Joint venture ownership arrangements have no apparent negative effects on hospital and nursing home services. For ambulatory surgical services, home health services, durable medical equipment suppliers, and radiation therpay services, some potential problems exist but our data did not allow us to draw definitive conclusions. For clinical laboratories, diagnostic imaging services, and physical therapy services, our results indicate significant negative impacts on access, significantly higher utilization and significantly higher charges at joint venture facilities.

EXHIBIT A

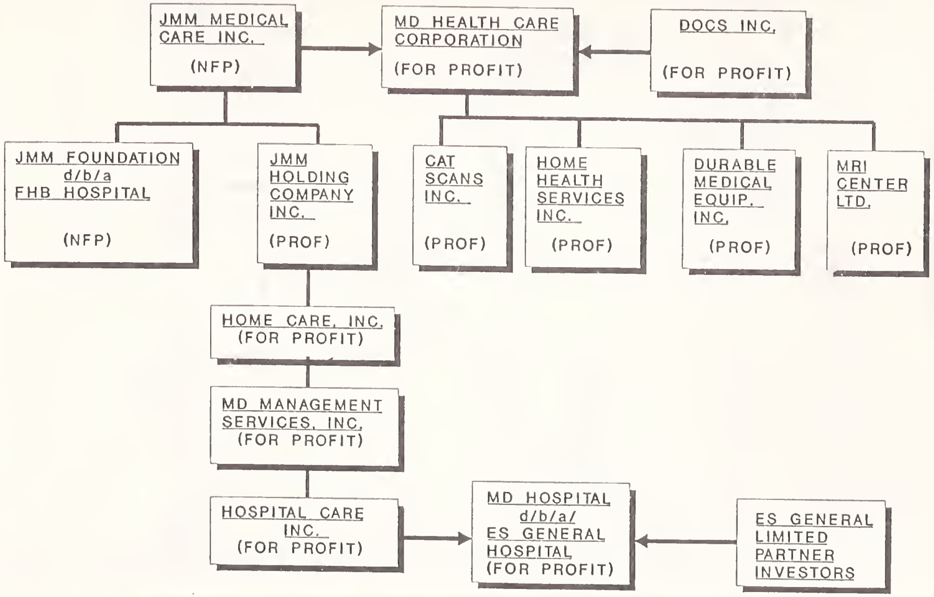
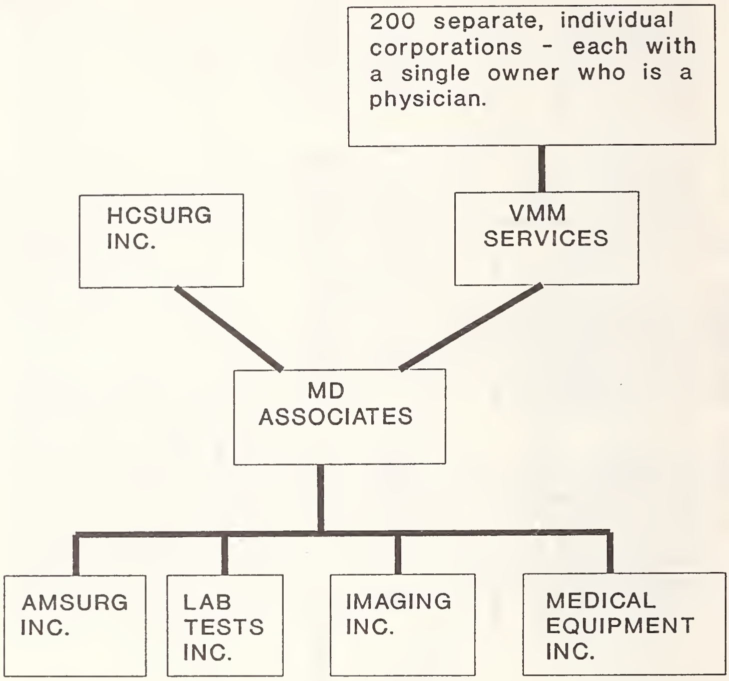

JMM MEDICAL CARE INC. (NFP)
MD HEALTH CARE CORPORATION (FOR PROFIT)
DOCS INC. (FOR PROFIT)
JMM FOUNDATION d/b/a FHB HOSPITAL (NFP)
JMM HOLDING COMPANY INC. (PROF)
CAT SCANS INC. (PROF)
HOME HEALTH SERVICES INC. (PROF)
DURABLE MEDICAL EQUIP. INC. (PROF)
MRI CENTER LTD. (PROF)
HOME CARE, INC. (FOR PROFIT)
MD MANAGEMENT SERVICES, INC. (FOR PROFIT)
HOSPITAL CARE INC. (FOR PROFIT)
MD HOSPITAL d/b/a/ ES GENERAL HOSPITAL (FOR PROFIT)
ES GENERAL LIMITED PARTNER INVESTORS

EXHIBIT B



200 separate, individual corporations - each with a single owner who is a physician.

Table 1 Physician Owners Classified By Specialty and Investment Choice

Specialty Group	Ambulatory Surgical Facility (1)	Clinical Laboratory (2)	Diagnostic imaging Center (3)	Durable Medical Equipment (4)	Home Health Agency (5)	Physical Therapy/ Rehabilitation (6)	Radiation Therapy Center (7)	Acute Care Hospital (8)
Total Physician Owners	645	1261	3340	595	1040	479	172	493
General Medicine	18 (2.8%)	252 (19.9%)	358 (10.7%)	83 (13.9%)	70 (6.7%)	50 (10.4%)	12 (7.0%)	59 (12.0%)
OB/GYN	127 (19.7%)	61 (4.8%)	233 (7.0%)	22 (3.7%)	53 (5.1%)	10 (2.1%)	2 (1.2%)	39 (7.9%)
Internal Medicine	147 (22.8%)	638 (51.0%)	1172 (35.1%)	215 (36.1%)	341 (32.8%)	92 (19.2%	62 (36.0%)	166 (33.7%)
Surgery	90 (13.9%)	52 (4.1%)	235 (7.0%)	49 (8.2%)	111 (10.8%)	21 (4.4%)	14 (8.1%)	61 (12.4%)
Orthopedics	105 (16.3%)	40 (3.1%)	254 (7.6%)	39 (6.6%)	45 (4.3%)	149 (31.2%)	–	33 (6.7%)
Neurology	5 (0.7%)	17 (1.3%)	228 (6.8%)	21 (3.5%)	69 (6.6%)	49 (10.2%)	2 (1.2%)	11 (2.2%)
Pathology	3 (0.5%)	81 (6.4%)	25 (0.7%)	10 (1.7%)	23 (2.2%)	2 (0.4%)	2 (1.2%)	7 (1.4%)
Radiology	3 (0.5%)	6 (0.5%)	297 (8.9%)	39 (6.6%)	66 (6.3%)	14 (2.9%)	28 (16.2%)	16 (3.2%)
Oncology	2 (0.3%)	23 (1.8%)	92 (2.8%)	14 (2.4%)	25 (2.4%)	2 (0.4%)	43 (25.0%)	12 (2.4%)
Other[a]	145 (22.5%)	91 (7.1%)	446 (13.4%)	103 (17.3%)	237 (22.8%)	90 (18.8%)	7 (4.19%)	89 (18.1%)

Notes: [a]Other - This category includes pediatrics, ophthalmology, anesthesiology, podiatry, chiropratics and the specialties listed in the "Other Doctor" classification in Table 5.

Table 2 Scope and Structure of Joint Venture Arrangements in Florida [a]

Facility Type	Total Number of Responding Facilities	Physician Owners Only	Physician Owners with Health Care Entities and/or Professionals	Health Care Entity and/or Nonphysician Health Care Professional Owners	Wholly Owned Subsidiary of SEC listed Companies	Other - NonProfit Government, and Non health care Owners
Ambulatory Surgical Facilities	68	33 (48.5%)	19 (27.9%)	1 (1.5%)	11 (16.2%)	4 (5.9%)
Clinical Laboratories	169	84 (49.7%)	18 (10.7%)	10 (5.9%)	25 (14.8%)	32 (18.9%)
Diagnostic Imaging Centers	160	105 (65.6%)	43 (27.5%)	2 (1.3%)	7 (4.4%)	2 (1.3%)
Durable Medical Equipment Suppliers	297	22 (7.4%)	38 (12.8%)	76 (25.6%)	35 (11.8%)	126 (42.4%)
Home Health Agencies	404	15 (3.7%)	35 (8.7%)	79 (19.6%)	182 (45.0%)	93 (23.0%)
Hospitals	227	7 (3.1%)	5 (2.2%)	11 (4.8%)	138 (60.8%)	66 (29.1%)
Nursing Homes	506	31 (6.1%)	26 (5.1%)	64 (12.6%)	242 (47.8%)	143 (28.2%)
Physical Therapy/ Rehabilitation Centers	262	50 (19.1%)	50 (19.1%)	130 (49.6%)	14 (5.3%)	18 (6.9%)
Psychiatric Hospitals	44	1 (2.3%)	1 (2.3%)	1 (2.3%)	33 (75.0%)	8 (18.2%)
Radiation Therapy Centers	23	14 (60.9%)	4 (17.4%)	--	2 (8.7%)	3 (13.0%)
TOTAL	2160	361 (16.7%)	246 (11.4%)	368 (17.0%)	690 (32.0%)	495 (22.9%)

Notes: [a] Excludes mental health treatment centers because none of these are involved in joint ventures.

Summary of Results on Problematic Joint Venture Facilities in Florida

	JOINT VENTURE FACILITY TYPE:		
	Clinical Laboratories	Physical Therapy Facilities	Diagnostic Imaging Centers
Access to poor persons	Significantly lower		Low*
Access to Medicare Recipients		Significantly lower	Low*
Utilization	Significantly higher	Significantly higher	Significantly higher*
Charges	Significantly higher	Significantly higher	Not compared*
Profitability		Significantly higher	Significantly higher

Source: Joint Ventures Among Health Care Providers in Florida: Volume II. State of Florida, Health Care Cost Containment Board in conjunction with The Department of Economics and The Department of Finance, Florida State University.

* These comparisons were not tested statistically because almost all Florida facilities were joint ventures. Utilization comparisons are based on comparing three Florida MSAs to Baltimore MSAs.

Chairman Stark. Thank you very much for most interesting and informative testimony.

Dr. Mitchell, I believe that this study that you and Dr. Scott directed was the result of an inquiry by the Florida State Legislature, is that correct?

Ms. Mitchell. Yes, it is.

Chairman Stark. And had you worked for them before?

Ms. Mitchell. No.

Chairman Stark. So, if I understand the genesis of this, somebody in the Florida State Legislature decided that this was an area that ought to be investigated, and through a bidding process or some independent selection process, the University of Florida and the two departments that you represent were selected, is that——

Mr. Scott. Florida State University.

Ms. Mitchell. The Florida Legislature mandated this study during the 1989 session and they requested that the Health Care Cost Containment Board conduct the study. The board contracted with us to do the study.

Chairman Stark. Who is us?

Ms. Mitchell. Dr. Scott and I, representing Florida State University, we are the principal investigators who did all the work.

Chairman Stark. In other words, it was not your doctoral dissertation of some years back that prompted this thing?

Ms. Mitchell. We are both tenured associate professors.

Chairman Stark. And your field, Dr. Mitchell, is economics?

Ms. Mitchell. Yes, I specialize in health care.

Chairman Stark. And, Dr. Scott, your field?

Mr. Scott. Finance, and I have specialized in health care finance and health care economics.

Chairman Stark. Dealing with issuance of bonds and——

Mr. Scott. My other specialty is our financial modeling dealing with investments, options.

Chairman Stark. You are both comfortable with the free enterprise system?

Mr. Scott. Absolutely.

Chairman Stark. Dr. Mitchell.

Ms. Mitchell. Yes. Economists believe in competition.

Chairman Stark. OK. All I am trying to establish is that you were not hired by doctors with a complaint that somebody else was stealing their business, but that you sort of came to this at the request of the legislature. Do you know what prompted the legislature to get into this?

Ms. Mitchell. This is secondhand, and apparently there is a legislator down in south Florida, this situation was brought to his attention by some hospitals down there that felt like they were being hurt by physician joint ventures, and it happened during the 1989 session.

Chairman Stark. Thank you.

You have each gone into some detail as to how you collected the data. Could you discuss whatever evidence you were able to find or whatever opinion you were able to form in terms of quality or access for whomever ends up paying the bills for medical care, generally the taxpayers? I know you are no authorities in that area, but that is an issue that is generally in our minds when we talk about health care. Could you find any benefits to the good folks in Florida from having this proliferation of ownership arrangements between physicians and these testing facilities?

Ms. MITCHELL. There did not appear to be any significant benefits, based on the data that we collected, with the exception of nursing homes.

Mr. SCOTT. I would add to that that you need to keep in mind that what we report here are averages, and, as such, the averages do not mean that everyone who is invested, every physician who had invested was in any way overutilizing, overcharging, or anything else, but it means that systematically, their averages were higher for charges, higher for utilization and that access was more limited when we report such results. So, "on average" I think is a key word to install there as to the effects.

Ms. MITCHELL. The other point, Mr. Stark, that we do not make any claims about inappropriate utilization. All we can say is that the utilization is higher.

Chairman STARK. Was higher. I think, Dr. Mitchell, you suggested that it was in diagnostic imaging that almost every physician—is that the area where the highest incidence of ownership exists?

Ms. MITCHELL. Yes, approximately, I think it was 3,400 physicians in the State of Florida have investment interests in diagnostic imaging facilities.

Chairman STARK. How many physicians are there?

Ms. MITCHELL. There is approximately 25,000 physicians who are active in the State of Florida, but you have to compare it to the appropriate base. There are 18,250 who are involved in direct patient care, and that excludes anesthesiologists, radiologists, and pathologists.

Chairman STARK. I have always felt that if the practice of physician ownership in a facility to which they refer became pervasive enough, if everybody owned a piece of every imaging center, the only result would be no difference in quality or access or anything else, but the net result would just have to put a layer of cost on top of the aggregate cost of imaging to, in effect, pay the dividend, interest and/or commission. There would be no net gain, no one center would have any more advantage, and you would just add kind of a layer. Is it the net result and don't you come very close to it in Florida, to say all you have done is raised the cost to everyone and have no real change in competition or am I missing something? I think you are suggesting that you get very close to that.

Ms. MITCHELL. In diagnostic imaging, there does not appear to be competition with nonjoint venture providers, because there are none or relatively—of all the facilities that responded to our survey, there was only one nonjoint ventured MRI center.

Of the nonrespondents—and we contacted all the nonresponding diagnostic imaging facilities—there were only two nonresponding facilities that provided MRIs or CAT scans. Most of the——

Chairman STARK. You are getting close to what I am asking. Let us assume for a minute that, in general, every MRI in Florida is owned by physicians who refer to it. What possible results can that relationship have, except that if you assume, as Dr. Scott said, on average, that the doctor receives 10 percent return for no at-risk investment, all we have done is put a commission on top of every diagnostic imaging procedure and, on average, every doctor gets a 10-percent fee for referring, and we have accomplished nothing.

Mr. SCOTT. Except to add to the cost, I think that is correct.

Chairman STARK. That is the point I am making. Is there any other result that one could——

Mr. SCOTT. I think there is possibly a result in terms of the—basically, patients are very loyal to physicians, by and large, and, therefore, if the physician is an owner and makes referrals to a facility they own, you have lessened the competition for that group of patients and you might have—and there are some studies that have tried to look at this, but it is very difficult—you would logically expect there could be a deleterious effect on quality. That is, you might not have persons involved in that business who were as qualified.

If, rather than having all the physicians with ownership and adding to the charge, you had all the imaging centers competing with each other to provide services, I think physicians without an economic incentive would be inclined to seek the best services they could get from those centers.

Ms. MITCHELL. The other point to make here, too, is that—never mind, I forgot what I was going to say. [Laughter.]

Chairman STARK. Let me ask this: Can you, in your opinion, transfer the economic behavior in Florida to other States? Is there anything about Florida that suggests that this result would be unique? Is there any reason that in Texas or California or Pennsylvania, that eventually all diagnostic imaging centers, for instance, would not eventually be owned by referring physicians, or is there something that you could suggest to the committee that says this is a Florida problem and could not apply in other States?

Ms. MITCHELL. It is not a Florida problem, it is something that we were made aware, in the process of doing the survey, that in some areas of the country it is probably as prevalent as it is in Florida, for example, California and Texas. We received calls from people out there working on this who indicated to us that, yes, they believed this was quite prevalent out there and it was causing some problems.

Chairman STARK. So, it is not a result of Florida having a higher percentage of retirees or the snow birds or there is not some unique factor, the delightful weather that is almost as nice as California or——

Mr. SCOTT. There is also another part of this study, wherein we surveyed regulators in other States. Another colleague, conducted a survey of regulators, to have them assess the significance of the problem, and there are many States where it is less problematic. In some States, the entry into any health care business is far more regulated than it is in Florida.

But to the extent that regulation was absent and there was a reasonable base of patients, populous States, it appeared in the minds of the regulators that it was a growing problem for them, so Florida may be ahead of the pack or may not, but there certainly appear to be problems that are more pervasive than Florida.

Chairman STARK. The committee will recess for about 5 or 6 minutes, until Chairman Pickle returns, and we will ask him to continue. Please excuse us for a moment.

[Recess.]

Chairman Stark. The hearing will resume.

I note the presence of the ranking member of the Health Subcommittee who has joined us, and I will recognize him out of order for a moment to inquire, and then we will proceed as the other members return from the vote.

Mr. Gradison.

Mr. Gradison. Thank you very much for recognizing me out of order, Mr. Chairman.

I regret that I was not here at the outset of the hearing. I have had a chance to read the testimony of these witnesses, and so I just want to focus on a couple of questions relating to the next steps. What do you all recommend we do about this?

Ms. Mitchell. It is a difficult question to ask us. We are not policymakers.

Mr. Scott. I would say the one thing that is clear is that, to the extent that joint ventures are not excessively profitable, I do not think there is a detrimental effect on the consumer, and I think that is the one thing that comes through here, is that there are indications that, if you allow joint ventures, they do produce excessive profits and that, to the extent you can do something that would eliminate the motives for overutilizing or overcharging, that is sort of a general issue and maybe even too general to be useful to you.

Mr. Gradison. Are you going to be making recommendations to the Florida Legislature?

Mr. Scott. No, sir. We have presented this study to the Health Care Cost Containment Board. The staff there is currently working on a set of recommendations which will be presented to the Florida Health Care Cost Containment Board at the end of this month, I think next week, and those recommendations will be forwarded to the legislature, and that information I am sure could be provided to the committee from the staff of the Health Care Cost Containment Board.

Mr. Gradison. One final question, Mr. Chairman.

I could not tell from your study whether there might be certain areas of your State which would be adversely affected, if these arrangements were prohibited, in particular, rural areas, where it might be difficult otherwise to raise the capital for some of this high-cost equipment.

I am just curious whether you broke out the figures for the size of the community or the distance from a major competitive health care facility or anything like that.

Ms. Mitchell. We found that none of the joint venture businesses were located in medically underserved or rural areas. Furthermore, with the exception of a few hospitals and nursing homes, none of the nonjoint venture businesses were located there, either.

To us, as economists, this makes sense, because you are never going to operate a business in an area where you are not going to generate the volume of patients to break even. So, in terms of geographic access, these do not increase access to persons in medically underserved areas.

As a matter of fact, there were no MRIs or CAT scans in any county in Florida with less than 100,000 persons.

Mr. GRADISON. I am sorry, would you repeat that last statement?

Ms. MITCHELL. There were no MRI or CAT scans——

Mr. GRADISON. In metropolitan areas?

Ms. MITCHELL. No, there were no MRI or CAT scan centers in counties with less than 100,000 persons in Florida.

Mr. GRADISON. Thank you.

Thank you, Mr. Chairman, for the chance to inquire.

Chairman STARK. Thank you, Mr. Gradison.

Mr. Pickle.

Chairman PICKLE. Thank you, Mr. Chairman.

I am going to follow through on that last statement, because I think it is important. Your statement was that there were no MRIs in the rural areas of a joint venture nature. The inference would be that they are going only to metropolitan areas and that the rural service is not being attended to.

But you have also now said that there were no MRIs by nonventures in the rural areas, so the rural areas are really not being served. The question is why, and I presume it has to be because they are so expensive, and it would be natural that they would go to the metropolitan areas first, because of the volume possibility, so at least I assume that is a premise to start with.

I want to be sure that I understand you, though. When the chairman asked you, you said this practice was being investigated by the State Legislature. It is not an investigation, it is a study or review, as you said, Dr. Mitchell, and in that light I think we ought to look at it, not as an "investigation" of some fraudulent practice, but as a "review" of how imaging centers are being established. I think that is fundamentally something we ought to keep in mind.

The complaint was that hospitals were not getting the service, instead of these imaging centers, these joint ventures. It would be natural that they would complain or be bothered about it, because it is a concern for all of us.

Now, you know, when you get to talking about imaging facilities and physical therapy services, clinical laboratories, they are all very needed and vital services that the people should have. Would you agree with that?

Ms. MITCHELL. Yes, I would.

Chairman PICKLE. Particularly, in the area of MRIs, they are very expensive. If a CAT scan or similar type of facility costs upward of $1 million or more, that is a problem for any community, particularly a rural area. So, to get them started, there has got to be an investment. I personally think it is because the physicians are willing to make the investment.

Now, suppose they did not, supposed it would be against the law for them to do it, would you say that those same facilities would be in doctors' offices? Where else would they go? They would go either to doctors' offices or in a hospital, would they not?

Ms. MITCHELL. Well, if ownership by referring physicians were banned, a radiologist could own imaging centers. Radiologists are not in a position to make referrals to the facility that they have an ownership interest in. Hospitals could provide the services, also.

I should note here that several of the imaging centers in Florida are owned jointly by hospitals and several limited partners who are physicians.

Chairman PICKLE. I do not find that difficult to accept. I think the wider the ownership, probably the better for us. I would be particularly interested in knowing what this Florida panel recommends, because it is a problem that we should address, but I do not think we should just automatically assume that everybody is just trying to do this for profit and profit alone.

Ms. MITCHELL. I agree.

Chairman PICKLE. I assume that your study is in agreement with that general approach.

Now, you have also said something very important to me, that your study did not find that there was overutilization in Florida, indicating some graft or corruption, but, rather, it was higher utilization, and that I think would be normal. But it is not overutilization, am I correct in hearing you?

Ms. MITCHELL. Mr. Pickle, we cannot determine whether the utilization was inappropriate. We can only say that it was, on average, higher in facilities which were owned by referring physicians.

Chairman PICKLE. All right. Let us take that point, comparing it to Baltimore. You said over in Baltimore that they did not have many of the MRIs in proportion to the amount in Florida, and, therefore, that the degree of use or utilization in Florida was much greater. Does it not follow that that is because there are so many elderly people in Florida, by comparison to the Baltimore area?

Ms. MITCHEL. We controlled for that. We only made comparisons between Baltimore and three Florida SMSAs, Jacksonville, Miami, and Orlando, that had similar socioeconomic characteristics. They all had a similar proportion of elderly, similar per capita income.

Chairman PICKLE. Well, in Baltimore——

Mr. MCGRATH. Would the gentleman yield?

Chairman PICKLE. I will in just a minute. My time is going.

In Baltimore, were there any nonphysician owned MRIs or joint ventures?

Ms. MITCHELL. Just one.

Chairman PICKLE. Just one. Were their charges much less than the Florida charges?

Ms. MITCHELL. We did not evaluate charges, because Maryland is a ratesetting State, and Florida is not.

Chairman PICKLE. Well, it seems to me that the charges seem to be at the very heart of what we are trying to get at, and what I am trying to find out is, are not the charges relatively the same, whether it is a physician owned or whether it is a nonphysician owned? Do you have any way to respond to that? Do you know?

Ms. MITCHELL. Well, in Maryland, a large proportion of the MRIs are provided at outpatient departments of hospitals, and, therefore, they are under ratesetting.

Chairman PICKLE. Mr. Chairman, I yield to Mr. McGrath.

Mr. MCGRATH. I thank the gentleman for yielding.

I just want to see if I can make a point of this distinction you are drawing between Florida and perhaps Maryland. I am just wondering whether or not Florida is a certificate of need State, in terms of limiting the availability either in not-for-profits, public hospitals or whatever, limiting the availability of these kinds of machines like an MRI or a CAT scan or whatever.

Ms. Mitchell. In freestanding centers, they are not subject to certificate of need regulations.

Mr. McGrath. I guess that is my point. In New York, we have a very similar circumstance, where all of the hospitals and the public providers are under a very, very stringent certificate of need process, whereas doctors are not. I do not know why they are not, but, at the same, they are simply not.

Now, it might account for the disparity between the numbers of procedures done in-hospital, as opposed to those done in a freestanding environment. I am just wondering whether or not your survey took into account that kind of a distinction, and, secondarily, whether or not it took into account the evolution of the practice of medicine from the x ray, perhaps, to the MRI and to some other imaging procedure.

Because of medical malpractice and a whole bunch of other things, where doctors are now faced with higher insurance cost, they are perhaps practicing more of a defensive kind of medicine and ensuring that all procedures that would be required are now done in order to protect themselves to some extent. I just wonder whether a distinction between a certificate of need State and a distinction of how the evolution of the practice of medicine has now evolved have any relevancy in your particular survey.

Mr. Scott. It would seem to me that doctors in Baltimore would have the same peril for malpractice suits as doctors in Florida. Again, the comparisons we made were limited to similar MSAs, in terms of the income, the age composition, and we compared also the major causes of hospitalization, those were similar, as were the 10 leading causes of deaths for the Florida MSAs and the Baltimore MSA.

The access to the services in Baltimore, because of Maryland's ratesetting system and the third-party payer system, should have been more free than access to services in Florida. In other words, their health insurance system is one that would ostensibly offer greater access.

The certificate of need law in Florida limits hospitals from building such facilities within the hospital, but does not preclude the hospital from entering into a partnership or a corporation outside and separate from the hospital that could provide these services, nor does it preclude private persons generally, not health care professionals at all from setting up such businesses.

I do not know if that answers your question or not.

Ms. Mitchell. Two more points on this issue; Baltimore has two medical schools, which would tend to lead to higher utilization of MRIs and CAT scans. Furthermore, we obtained information from the Maryland Health Services Commission that, since Baltimore is a relatively isolated area, patients are not going to—you are not going to have the border-crossing problem that you would have like, for example, in New York City, where patients from within New York City would be going to maybe New Jersey to get services. In Baltimore, they tend to stay there and have the diagnostic services performed there.

Mr. Cardin. Would my colleague from New York yield?

Mr. McGrath. I yield.

Mr. CARDIN. Let me first explain that I represent Baltimore, and I am not sure whether I should be concerned or pleased that we have so few joint venture physician-owned diagnostic imaging centers in our community.

Let me raise one concern. Mr. Pickle pointed out that it could be an advantage to have joint venture, physician-owned facilities, in that they provide the capital and the know-how to bring new technology and services to a community that otherwise may not be there if we were to prohibit this source of funding.

Were the people of Baltimore denied access to imaging centers as a result of not having the same participation by physicians in joint venture ownership as you saw in Florida? Did you see any evidence that this technology was not available to the people of Baltimore?

Ms. MITCHELL. No, we did not, and there are freestanding centers in Baltimore that are owned by radiologists who are, as we said before, nonreferring physicians, and they are providing the services. So, if there was a ban put on having referring physician ownership, radiologists could still provide these services. From what we understand, radiologists have been hurt by having referring physician involvement in these arrangements.

Mr. CARDIN [presiding]. So, the bottom line is that access in Baltimore has not suffered as a result of having fewer joint ventured owner——

Ms. MITCHELL. No, it does not appear to be the case.

Mr. CARDIN. Now, you did not make a comparison on actual costs, but you did, I understand, on profits or cash-flow? Is that how you did it, Dr. Scott?

Mr. SCOTT. Yes, sir. On the, if you will, net operating margin for the facility, not the net, I am sorry, but just the operating margin before paying fixed expenses. What was left after subtracting from net revenues, we subtracted direct charges for providing the services.

Mr. CARDIN. Assuming one of our goals is to keep medical costs as low as we can, it is my understanding that the Baltimore cash-flow compared favorably to Florida? That is not correct?

Mr. SCOTT. No, sir, we did not—the only comparison for Baltimore was on utilization.

Mr. CARDIN. Just utilization?

Mr. SCOTT. Right.

Mr. CARDIN. So, Baltimore utilization compared favorably to Florida?

Mr. SCOTT. Yes, sir.

Mr. CARDIN. Of course, utilization has a direct impact on cost, also.

Mr. SCOTT. Yes, sir.

Mr. CARDIN. So, from the point of view of overall medical cost, Baltimore at least compared favorably to Florida in that regard?

Mr. SCOTT. Yes.

Mr. CARDIN. And we can draw whatever decisions we want from that.

Mr. SCOTT. Yes, sir.

Mr. CARDIN. I notice that you had no significant comparison as far as DME was concerned. I have introduced legislation that would prevent referrals by physician owned DMEs. What findings did you report in regard to DME referrals?

Ms. MITCHELL. We collected information and we found that from the medical equipment suppliers that responded to our survey, approximately 20 percent were owned by referring physicians. It was very difficult to make any kind of utilization or cost comparison, because of the fact that some of these businesses specialized in the provision of oxygen services, whereas, others specialized in providing wheelchairs and hospital beds. Those two types of businesses are not comparable, and if we had made comparisons, it would have been like comparing apples and oranges.

We did find, however, that joint ventured businesses were significantly more profitable than nonjoint ventured businesses, and we found a particular problem with the shell corporations in the State of Florida.

Mr. CARDIN. Let me apologize and turn the gavel over to Congressman Levin. We have about 3 minutes left on the vote, so I need to leave.

Mr. LEVIN [presiding]. Mr. Cardin will read the end of your response in the record, if you had not finished. Have you finished?

Ms. MITCHELL. Yes.

Mr. SCOTT. Yes, sir.

Mr. LEVIN. I may cover some ground that others have, because I, of course, was gone for a bit. You know, we do these hearings seriatum, instead of getting contending forces together on the same panel, and it might be of interest, if you would comment on some of the testimony that is going to come later, because on the last panel there is some testimony that disagrees with your data or with the conclusions that some would pull from your data.

So, let me just ask you, there is a distinction in Mr. Mills' testimony between the self-referral mechanism when it comes to analytical tools and therapeutic, and it says that the study recommends prohibiting physician self-referrals only in three areas. The three areas mentioned in his testimony are physical therapy, diagnostic imaging, and clinical labs.

Do you think your data would indicate that those are the main or only areas of problem, or it might be more broad than that?

Ms. MITCHELL. We grouped the facilities into three categories where we perceived no problems, problematic, and then a third group which we called inconclusive. In the inconclusive group, there were four types of facilities, ambulatory surgery, durable medical equipment, home health, and radiation therapy.

The reason we put them in the inconclusive group is that we found problems or indications of problems, but the sample sizes were small or we were not able to make the appropriate comparisons.

For example, in multispecialty ambulatory surgical facilities, we found access problems. We found some indications of higher utilization of home health agencies, but we had only been able to make the comparisons for one type of home health agency, these larger type homes. We could not say anything about home infusion.

In durable medical equipment, as I just stated, we were not able to make any comparisons on utilization, because of the diverse nature of the services provided. It would have been inappropriate for us to compare a business specializing in oxygen services to a business which specializes in providing canes and wheelchairs.

We did find problems with shell corporations, though, in durable medical equipment. So, it is not that inconclusive area. We put them there, because there are potential problems, but the data we collected did not allow us to draw concrete conclusions.

Mr. LEVIN. All right. So, the rather rigorous, if not rigid line that Mr. Mills would have us draw, you do not think is supported by your study?

Mr. SCOTT. I would say that there is sort of the turning of a phrase there, and I think possibly Mr. Mills refers to the forthcoming recommendations for policy by the Health Care Cost Containment Board, rather than our study, because we did not make policy recommendations in this study.

But the results that we have were clear in three areas, and as Dr. Mitchell stated, they were less clear in other areas, and we have heard responses from people in radiation therapy and from infusion therapy, that there is virtually no opportunity for abuse and, therefore, this should not be considered.

It is not at all clear to me that that is the case, and the results that we got did not indicate there was a problem, but it did not indicate there were no problems. There were areas where we found no problems, and the areas that are cited in the subsequent testimony—and we have been through some of the prepared testimony—do not fall into that clearly no problem area.

Mr. LEVIN. Now, another critique in his testimony is that your study does not identify the positive impact that—I am reading from page 4—new health care joint ventures have had in three key areas, cost, access, and quality.

You are an economist—are you both economists? I forget.

Ms. MITCHELL. I am an economist. Dr. Scott is a finance professor.

Mr. LEVIN. OK.

Mr. SCOTT. I am a financial economist.

Mr. LEVIN. A financial economist. So, that may be a bit of a sensitive criticism, you were not sensitive to issues of cost.

The testimony goes on to say that there will be elimination of competition, if there were this kind of a rigorous ban, and that has not been taken into account; nonphysician providers will dominate local markets and will raise prices. Any comment on that critique?

Mr. SCOTT. I would say there is no evidence that supports the claim that was just stated. The evidence that we have is that if physicians are in a position to make referrals and you are trying to compete with that physician, that you are unlikely to succeed.

That is a common complaint we got, as we collected data, and the evidence that we have, these three areas where we found clear evidence of abuse are areas where physician investment in these businesses is among the highest, so that the impact on competition, to the extent that it is indicated in our results, is that physician investment in these businesses has not increased competition, it has increased charges and utilization, or there are increased utilization rates and increased charges at physician-owned businesses compared to the nonphysician-owned businesses, and that profits are much higher where physician investment is more common and where referrals by owning physicians is more common.

Mr. LEVIN. Let me ask you one further question, and then I see that Mrs. Johnson has returned, and I would ask if she would like to participate. I have used my 5 minutes.

There is also a comment on page 5, and this relates to access, and you have really touched on this. It says, in the second paragraph,

> Indeed, while the study notes that physician investment was high in specialties such as radiation therapy, it does not consider how quickly patients, particularly in small cities and rural areas, would obtain access to that treatment absent that physician investment.

I come from Michigan. I had a chance some years ago, with Bob Traxler, to look at facilities in the thumb, which is a smalltown area and rural, and there is obviously a lot of sensitivity to this kind of an attack or critique.

So, let me ask you, any further response to that suggestion about loss of access to such treatment absent physician investment?

Ms. MITCHELL. Mr. Levin, as I have stated before here today, proponents of joint ventures say that physician investment increases access, geographic access to persons in medically underserved areas.

We found that not to be the case in the State of Florida, however. None of the joint venture businesses were located in medically underserved or rural areas at all, and this was also true for non-joint venture businesses, with the exception of some hospitals and nursing homes.

So, to us, as economists, this makes sense, because it is unlikely that a business operating in a rural or medically underserved area is going to generate the volume of patients necessary to break even.

Mr. LEVIN. Before I turn it back to the two chairs, on page 6, there is reference—and Mr. Mills will have his crack at it, too—the study is biased against physician joint ventures. Do you have a bias?

Mr. SCOTT. No, sir.

Ms. MITCHELL. No.

Mr. SCOTT. Let me state that the way we set up the hypothesis that we tested was to basically state that physician joint ventures had favorable impacts or had neutral or favorable impacts, and only if there was significant evidence that that was not true, that is, if they were statistically significant, not just some higher utilization, but statistically significantly higher utilization, did we reject that premise that it was basically stated in the most favorable terms for physician joint ventures.

Had we been biased, we could have stated the hypothesis that joint ventures have deleterious effects on consumers, and we would have rarely rejected that hypothesis with the data that we have. Indeed, I do not think there would be three or four tests out of the hundreds that were done that would lead us to reject that hypothesis, had we set up such a bias against the joint venture businesses.

Mr. LEVIN. Thank you.

Chairman STARK [presiding]. Mrs. Johnson.

Mrs. JOHNSON. Thank you, Mr. Chairman.

Did you compare joint ventures that were physician owned with joint ventures that were not physician owned?

Ms Mitchell. Yes, we did.

Mrs. Johnson. And was there any difference in profit margins or charges?

Ms. Mitchell. In certain areas, we did find that to be the case. For example, physical therapy, clinical laboratories, we found significant——

Mrs. Johnson. Please enlarge on that.

Ms. Mitchell. I am sorry?

Mrs. Johnson. Please enlarge on it.

Ms. Mitchell. In clinical laboratories, we found significantly higher utilization. We also found significantly higher charges per patient, in terms of revenue per patient, both gross revenue and net revenue per patient.

In physical therapy, we found significantly more visits per patient in physician-owned facilities, and significantly higher revenue per patient, and also physician joint ventured physical therapy facilities were significantly more profitable.

Mrs. Johnson. And you did not find that in any other specialties, any other settings?

Mr. Scott. Could I ask you what you mean by a joint venture that does not include a physician? I am not clear on that.

Mrs. Johnson. Well, I was going to get to that next. That is another thorny problem, but at this point I was trying to differentiate between joint ventures that are owned by physicians and joint ventures that are owned by others.

Mr. Scott. Other health care professionals or other individuals?

Mrs Johnson. Other health care professionals, other individuals, corporations, whomever——

Mr. Scott. Then all our comparisons——

Mrs. Johnson [continuing]. And nonphysicians.

Mr. Scott. All our comparisons cover that, and so any conclusions we have would stand without amendment, in response to your question. All other conclusions would indicate, that is, the three problem areas indicate, yes, there is a difference when the physician is in the joint venture.

Mrs. Johnson. And differences in profits and in charges?

Mr. Scott. I have a table that appears at the end of our prepared testimony that points out where these differences were statistically significant for the three areas where we found clear patterns that indicated that joint ventures with physician ownership had negative effects on access or ended up with higher average utilization or higher average charges or higher average profits.

Mrs. Johnson. And did you look, in those instances of physician ownership, at what percentage of the physicians were also in a position to refer?

Mr. Scott. Yes, madam, we did, and this was summarized in an earlier table, just ahead of the very last page. In general, the physicians who were not in position to make referral would include pathologists for clinical laboratories. Relatively few of the clinical laboratories were owned by pathologists, and when we made comparisons there, there were some similarities between the labs owned by pathologists and owned by physicians who could make referrals.

Ms. Mitchell. The comparisons for clinical laboratories of joint venture/nonjoint venture focused on the referring physicians. We had grouped them into four types, specialty laboratories, those owned by pathologists, labs owned by referring physicians that provided courier service, and those owned by referring physicians that did not provide courier service, and we made comparisons only for the latter two groups of clinical labs, joint venture and nonjoint venture.

We did not make comparisons or detailed comparisons with labs owned by pathologists, because pathologists are not in the position to make referrals to the facility that they have an investment interest in.

Mrs. Johnson. You see, that would be very important, because if we are going to limit people's rights to invest, we need to be able to differentiate between certain categories. The reason I asked this is that, in my district, there are facilities that can document—this happens to be an MRI facility—that their charges are substantially lower than the hospital charges, and, therefore, they are saving all of the consuming public real dollars.

Now, in a way, from the public policy point of view, you do not want to cut out providers that are lower cost due to efficiencies, and our own HHS is trying to force all cataract surgery into the same place, so there will be lower costs. So, there are instances out there where costs are clearly lower, and if you could look back on your data to see what is the relationship between profits and cost, when there is physician ownership, but it is not nonreferral physician ownership, that would be useful to us.

Ms. Mitchell. Well, what we found was, in the case of imaging centers, there were very few imaging centers in the State of Florida which were owned solely by radiologists. Basically, radiologists have been hurt by joint ventures. They have been put out of business.

What has happened, apparently, is that we did have radiologists that were more or less general partners or provided the interpretation of the MRIs or CAT scans at these centers, but they were not the sole owners of the facilities.

Mrs. Johnson. Did you look at charges between hospital-based radiological groups and joint venture groups?

Ms. Mitchell. No, we did not make comparisons of charges that way. The problem is that hospitals treat an entirely different mix of patients than these freestanding facilities. Freestanding facilities do not treat much charity care or they do not take any Medicaid patients, so if we had made those kind of comparisons, it really probably would not have been appropriate.

The other thing, too, is you have to remember that hospitals have a lot more overhead, because they are operating 24 hours a day, whereas, the freestanding facilities are not doing that.

Mrs. Johnson. I appreciate all of those things.

Mr. Scott. I would say also on that, there is a difficulty in comparing, because of the way that payment is made for those services. For freestanding facilities, the payment is typically a global fee that includes compensation for the physician who reads the scans. Whereas, with hospitals, the hospital will obtain what is called a technical component or a facility fee only, and this also was problematic in making the comparisons.

Mrs. JOHNSON. It is a very difficult area, because we are denying a specific group of people the right to make investments, which in a market economy is sort of fundamental. It is hard to find by what measure you deny ownership—you are talking about on-average, and the problem with on-average is it does not distinguish between the abusers and the nonabusers.

Mr. SCOTT. Absolutely.

Mrs. JOHNSON. Whereas, charges might help us distinguish between the abusers and the nonabuser.

Mr. SCOTT. If you adjust the charges for the discounts and the writeoffs that are——

Mrs. JOHNSON. Yes, you would have to have a sophisticated approach to charges, you are absolutely right, try to get apples to apples and oranges to oranges.

Mr. SCOTT. Yes. I have looked in the main study, not the testimony, and the profits for pathologists owned laboratories are less than the profits are for the joint venture laboratories, and also less than the nonjoint venture owned laboratories, so that the physicians——

Mrs. JOHNSON. The profits, you could be more profitable because you are more efficient and charging less.

Mr. SCOTT. I understand.

Mrs. JOHNSON. So, profits do not help us, and in a sense they tend to color the debate.

Mr. SCOTT. I understand, and I think I may be repeating myself, but I will say again, profits are necessary, they drive the machines of our economy that produce goods and services. We need a reasonable rate of profit to encourage investment, and I hope I have not appeared anywhere to be against profit. It is excessive profit that would indicate an abuse of a physician, where people are not able to fairly compete or an abuse of a physician where physicians make referrals for the purpose of either charging more or excess——

Mrs. JOHNSON. One last question, because I see that the red light is on. Did you look at severity of illness in the Baltimore clientele?

Ms. MITCHELL. We only compared Baltimore to the three Florida MSAs, and we found that there was a similar incidence of disease, and the top 10 hospital conditions were also similar between the Baltimore MSA and the three——

Mrs. JOHNSON. Did you profile the type of tests done?

Ms. MITCHELL. You mean in terms of MRIs and CAT scans?

Mrs. JOHNSON. Yes.

Ms. MITCHELL. No, we did not.

Mrs. JOHNSON. It is tough for us dealing with these materials and making these decisions, but your evidence is clearest in the labs and physical therapy area. My anecdotal evidence is strongest in those areas, as well, although in durable medical equipment there are an enormous number of questions that arise.

But the other areas appear to me to be much, much more difficult, and any detail you can get back to the committee on some of the things that you did not compare, where the structure of physician ownership was different would be useful to us.

Thank you.

Chairman STARK. Mr. Shaw.

Mr. SHAW. No questions.

Chairman STARK. Mr. Pickle.

Chairman PICKLE. Thank you, Mr. Chairman.

I want to follow up with two additional questions. In January of 1992, a law will go into effect barring the referral to a physician-owned lab of any Medicare patient. That is only 2 months away. I wonder if this question has arisen in your study. What is going to happen when that law goes into effect? Do you have any feeling about that?

Ms. MITCHELL. Well, I know I can tell you that several of the formerly owned physician laboratories owned by referring physicians have been purchased by pathologists who are not in a position to make referral. Others have been purchased by national laboratories such as Smith-Kline and Allied, and they will be able to provide the services. Some other arrangements have just closed their business.

Chairman PICKLE. I have the feeling that this may be a more serious problem than we intended, because in the climate in which the law was passed, we thought there should be one way to stop a physician from just taking a poor Medicare patient and sending him to their lab, so we said you cannot do that to Medicare patients.

Now, if the physician cannot have any ownership, it seems to me like these things have either got to be sold or they just go out of business, and I am afraid we might be facing a more serious problem than we think, at least it looms as a serious problem to me. I do not know, either, if the big national medical labs, Smith-Kline and some others, buy them out, whether that is an improvement over our problem or not.

At any rate, I just want to get your reaction on that topic.

Ms. MITCHELL. Well, the national laboratories and the pathologists are not in a position to make referrals to the facility. Also, another thing that could happen is that these labs could be incorporated within the physician's practice, because group practices are exempt.

Chairman PICKLE. Yes, that could happen, but I do not know whether this committee would look with favor on that, because we are just trying to put that type out of business.

Let me ask you one other question: We now have, through HCFA, a limitation on amount of ownership that a physician can have I think of 60/40. Are those percentages viable, are they practical? Should we enlarge them or should we lessen them? Do you have any feeling about that?

Mr. SCOTT. Are you referring to the ownership or the proportion of business?

Chairman PICKLE. Both.

Mr. SCOTT. My sense is that the percentage of ownership limitation would not necessarily be a deterrent to setting up organizations where a physician may have a very small percentage, but if I can get 1 percent of $5 million in profit, then I made $50,000, and that I think is a key to remember.

Some of these businesses treat a very large number of patients, if they represent a very large number of physicians and if you have 1 percent or one-half percent and it is generating a lot of profits, that can still be a substantial number.

Chairman PICKLE. Thank you, Mr. Chairman.

Chairman STARK. I just wanted to review a couple of things with you, and then we will let you get on to lunch.

You are aware of the 1976 law that we are concerned about, the Medicare law which prohibits a physician from receiving anything of value for a referral. Now Professor Scott, you are an expert in medical finance, you are familiar with financing of hospitals, physicians' practices, and HMOs.

Mr. SCOTT. Yes, sir.

Chairman STARK. Do you see anything in the 1976 law that was directed or intended to deny anybody the right to make investments?

Mr. SCOTT. No, sir.

Chairman STARK. In other words, the law only refers to referral fees or fee splitting or kickbacks or commissions or whatever you want to call it, directly or indirectly. So, the law, basically—and there may be some issue of defining investment, but it does not prohibit anybody from making any investment they choose.

Also, there are certain physicians—I do not know what you call them in your study—who are specifically trained and/or licensed to operate either these labs or these imaging centers. I mean they are in the business of taking x rays or doing blood samples and all of that sort of thing, and it is my understanding that you found that less than 10 percent of those physicians were in an ownership position, or else they were the radiologists that owned his or her own x ray machine, and they are not part of the distortion in your study, are they?

Ms. MITCHELL. No, they are not.

Mr. SCOTT. I think, as you stated, the 10 percent is not 10 percent of the radiologists, but, rather, 10 percent of all the physician owners, and they certainly did not——

Chairman STARK. In other words, any physician in Florida who is specifically trained to operate a lithotripsy machine or an MRI or do blood sampling, is not who you are referring to, in terms of ownership or large profits, I do not believe.

Ms. MITCHELL. Mr. Stark, as I presented in my testimony, only 9 percent of our physician owners are pathologists, radiologists, or anesthesiologists. All the other physician owners are in a position to make referrals to the facilities which they have investment interests in.

Chairman STARK. In general, is there anything else that this 91 percent of the physicians would have to do with the facility, other than to refer patients to it?

Ms. MITCHELL. No, not at all.

Chairman STARK. In other words, they would not be apt to hire the technicians——

Ms. MITCHELL. No.

Mr. SCOTT. In general, it would not make sense for a physician, whose rate of pay for delivering services to patients is much higher than the rate of pay for a manager, to be in the facility and managing the facility, from an economic perspective.

Chairman Stark. So, in an economic model, I suppose the only reason a person would make an investment is economic return, convenience, perhaps some good feelings, psychic income, or he or she might enjoy owning an antique painting or something that gave you some pleasure. But is it safe to say that, in general, this group, the 91 percent, could have no other reason than economic reason to have this ownership?

Mr. Scott. Certainly, economic reasons——

Chairman Stark. Practicing in the area that this facility was being used for.

Mr. Scott. From the view of finance and investment, which is an area that I teach and have worked in for a number of years, people should seek investments that offer reasonable compensation for the risk that they take on in that investment. If a physician invests in a facility that they make referral to and there is no excessive profit, then the rate they earn there should be comparable to what they might earn if they had invested in a business that had nothing to do with health care or medicine.

Chairman Stark. Now, you get us into an area that I guess we are not competent to judge, nor should we, and you use words like "excessive." I might use words like "obscene" or "extra." [Laughter.]

But how do economists in the field of teaching finance, how would you define or quantify for me——

Mr. Scott. You must first define what risk means to you.

Chairman Stark. Well, give me a thumbnail on what is excessive. How do you outline that?

Mr. Scott. If I offer you an investment and I tell you that the returns vary from minus 30 percent a year to plus 50 percent a year——

Chairman Stark. To plus what?

Mr. Scott. Plus 50 percent a year.

Chairman Stark. Five-zero?

Mr. Scott. Five-zero, so the range is from minus 30 to plus 50, and I say that this investment will give you an annual return of 10 percent, and I offer you another investment and I say this investment offers returns from zero percent a year to 20 percent a year, they both have the same average return, but you can pretty readily tell me that either the zero to 20 is offering excessive returns, or the minus to plus is offering inferior returns, and that is the basic premise that financial economists operate from, when evaluating what is excessive.

You must first decide a reasonable measure of risk, which is typically associated with the amount of variation you get in the returns, and you measure that return component against that risk component, and if your reward to risk measure is much higher consistently than in a competitive situation, then you would say that one group is earning an excessive return, since we would assume, in general, that the other business is earning a normal return.

Mr. Gradison. Mr. Chairman.

Chairman Stark. Mr. Gradison.

Mr. Gradison. Is it not possible, though, that that is a matter of taking a snapshot, rather than looking at this through a moving picture? I mean, you took a snapshot. If you leave the situation alone long enough, is there not the likelihood that investment will continue to enter the field until the rate of return on the next incremental MRI or CAT scanner becomes marginal until price competition sets in, until some of them go bankrupt?

I am just trying to think of the implication of what you said. I mean maybe you just happened to look at it at a point in time when there are excessive profits, but if you leave it alone, we would come out the same as if we had regulated.

Mr. SCOTT. Yes, I agree, if normal forces of competition apply to the process we are dealing with. In a situation where a physician makes referral for services, normal forces of economic competition may not apply. Now, that physician may be in a position to direct the patient to the service to the company that they have an ownership interest in, and to the extent they do that, the patient is very likely to go to that service, and normal competition does not apply.

In normal competition, your statement is exactly correct, and that is what I would expect. But to the extent that physician-patient relationships exist that would lead patients' choice of service not to be dominated by consideration of cost quality, that does not apply in health care finance and health care economics.

Ms. MITCHELL. Another point to be made here is, in the case of an MRI or CAT scan or clinical laboratory work or physical therapy, we as consumers of health care do not have enough knowledge to know whether these services are necessary, so you place your trust in the physician to tell you that you need to go have an MRI done, and that also has the same effect.

Chairman STARK. Dr. Scott, in my pedestrian economics, is it not correct to assume that if there is no recourse or no cash in the investment, that the range of risk that you defined has to be from zero to infinity, by definition.

Mr. SCOTT. That is right.

Chairman STARK. Is that not correct?

Mr. SCOTT. That is correct.

Chairman STARK. In other words, if you do not put any money in, you cannot lose a nickel.

Mr. SCOTT. That is right.

Chairman STARK. And the amount of return that you are getting is 10 to the infinite power in return, you are getting thousands of percent profit.

Mr. SCOTT. Yes, sir, or even a nominal investment.

Chairman STARK. Were you able to ascertain any of the incidents or types of ownership that were prevalent in these ownership situations in Florida, or is that not part of your study?

Mr. SCOTT. We did not measure the amount that was invested. We did, in the course of our investigation, receive prospectuses which indicated very nominal investments of a few hundred dollars could produce returns in the thousands of dollars, but we did not measure the amount invested as part of our study.

Chairman STARK. I, too, have received copies of prospectuses that indicate that you do not have to put up any cash, you can borrow the money and the note is nonrecourse and you have no risk.

In that kind of an arrangement, is there any economic reason for my investment? I mean, is that any more than an endorsement? I mean, what is the economic result of my contributing a nonrecourse note to a venture?

Mr. SCOTT. When you enter into an ownership arrangement and you were to say for $100 and other valuable consideration, one valuable consideration there would be the referral base that a physician has, if the——

Chairman STARK. But absent that——

Mr. SCOTT. If there was no such opportunity?

Chairman STARK. Does it not stretch the mind of most economists? It is an interesting exercise, some might say, but to say if there is no risk in this instrument or this condition for participation, there is no economic reason then to be in the club. That is what I keep looking at and saying it leads me to conclude, at least, that in every instance that I have been made aware of—and those I guess would number into the thousands, if that still qualifies them as anecdotal—there has not been any risk.

Mr. SCOTT. This premise is sort of a standard for rejecting any theory in financial economics. If you, without risk, can earn anything, we say this is an impossibility, that it cannot exist in the real world and, therefore, we would reject any sort of premise like that.

In fact, there has to be something of value there, or you would not be offered that opportunity.

Chairman STARK. Were you aware of the other contractual relationships with the investor physicians and the laboratories? For example, in most of the cases that I have seen, the joint limited partnership or joint venture agreement specifically prohibited limited partners or joint venture investors from having any participation or voice in either the financial management or the professional control of the imaging center or laboratory. Did your study go into these types of arrangements?

Mr. SCOTT. I think in limited partnerships, such requirements are fairly common. Now, I think I have done some analysis of general limited partnerships which are problematic in the investment area, because of limited information provided to investors and so on, and in those cases these sorts of arrangements are fairly standard language in limited partnership arrangements, so I was not surprised that the limited partners were precluded from having any substantial impact on the management of the business.

Chairman STARK. My sense is that, although that may not be the case in California, in most States this is done to insulate the limited partner from being judged a general partner——

Mr. SCOTT. Right.

Chairman STARK [continuing]. But has the effect, nonetheless, does it not, of prohibiting the investor from having any say in the professional technical operation and/or the financial operation of the business?

Mr. SCOTT. By definition, they would not be able to contribute technical expertise or other useful management input.

Chairman STARK. Well, your study has been helpful. It is fascinating. As you are aware, there are studies being generated now by HCFA and by the GAO. Are you familiar with any of the work being done by those two organizations?

Ms. MITCHELL. Yes, we are.

Chairman STARK. Have you looked at both their forms and their questionnaires and their methodology?

Ms. MITCHELL. We met with the woman who is conducting the survey for HCFA, and she did show us her ownership form.

Chairman STARK. Is there anything that would lead you to believe that we cannot collate your results and whatever results we might expect from HCFA or GAO, or are you all approaching this in such different direction and methodology that we will not be able to build on each other's experience?

Ms. MITCHELL. Well, as the HCFA analysis and the GAO will only focus on Medicare, our study focused on the general population of consumers in Florida. The other thing is, in looking at the survey form for HCFA, I am not sure if it would get at all the indirect ownership of these facilities through parent corporations that we found to be very significant.

Mr. SCOTT. I think, however, that if ownership information provided is accurate, that the HCFA results will provide a clearer answer for Medicare beneficiaries, anyway, on the issue of whether the specialty is the reason for the higher utilization that we find in our study. I think that you should get a clearer answer from their study, because they are going to use claims data.

Chairman STARK. One of the criticisms of your study will, of course, be that certain specialists have more of a tendency, I suppose they make more money, so they have more money to invest and also they are more intimately involved with the particular type of procedure that they invest in.

You could argue also, I suppose, that your study is biased, on the basis that for non-Medicare billing, this procedure is perfectly legal, even if you assume that the only reason is to generate indirect deferrals. There is nothing wrong with that.

However, it is clearly illegal, if you determine that the only reason for the investment is to get a referral fee, that would be illegal under Medicare laws. How would you respond to the criticism that says, therefore, your study results will be much higher, because you have got this huge number of doctors who are not dealing with Medicare beneficiaries, doing legal things, and all HCFA and GAO will be doing is studying those who might be criminally charged, if, in fact, they had ownership? How do you respond to that, Dr. Mitchell?

Ms. MITCHELL. Mr. Stark, Florida has an antikickback law which parallels the——

Chairman STARK. How many years in jail?

Ms. MITCHELL. I am not exactly sure, but there——

Chairman STARK. Obviously not enough. [Laughter.]

Ms. MITCHELL. There are civil penalties that can be imposed.

Chairman STARK. There is a career for a bunch of U.S. Attorneys down there, aren't there? [Laughter.]

And is your information that you have collected privileged?

Mr. SCOTT. It is public.

Ms. MITCHELL. It is public.

Mr. SCOTT. Every bit of information that we have collected for this study is a public record. Florida has a very strong sunshine provision, and the legislature, when they passed the law to collect this data, chose not to exempt these results from the sunshine law provision, so that every bit of information we have collected and all the data we have are public records.

Chairman STARK. I hope you have a short statute of limitations, or you are going to have a shortage of doctors. [Laughter.]

Mr. McGrath.

Mr. MCGRATH. No questions, Mr. Chairman.

Chairman STARK. Any of my colleagues?

[No response.]

Chairman STARK. I again want to thank you. It is a fascinating study. I know that we will want to look at it in more detail. Are you going to continue this? Is there a second edition coming?

Ms. MITCHELL. Dr. Scott and I are researchers and our major reason for getting involved in this project was because the subject interested us, and so we plan to analyze the data further and write some more papers from it.

Chairman STARK. We will be looking forward to that.

I want to thank you both very much for being with us today.

Ms. MITCHELL. Thank you.

Mr. SCOTT. Thank you.

Chairman STARK. It is the Chair's intention to continue through lunch and to completion, and with that in mind, the other witnesses may want to schedule their lunch breaks accordingly.

The next witnesses are a panel consisting of Dr. James Moorefield, who is chairman of the board of chancellors of the American College of Radiology; Dr. Michael Isikoff, who is a staff radiologist at the Parrish Medical Center, in Titusville, Fla.; and Robert D. Carl III, who is president and chief executive officer of Health Images, Inc., of Atlanta, Ga.

We welcome the witnesses to our committees. With the concurrence of my cochair, Mr. Pickle, we will put your prepared testimony in the record in its entirety and ask you to summarize or expand on your testimony in approximately 5 minutes, which will give the members of the committee a chance to inquire.

We will ask you to proceed in the order that you are listed on the witness list. Dr. Moorefield, would you like to lead off?

STATEMENT OF JAMES M. MOOREFIELD, M.D., CHAIRMAN, BOARD OF CHANCELLORS, AMERICAN COLLEGE OF RADIOLOGY

Dr. MOOREFIELD. Thank you, Chairman Stark and Chairman Pickle.

I am James Moorefield. I am a radiologist from Sacramento, and I serve as chairman of the board of chancellors of the American College of Radiology.

I am very pleased to have the opportunity to give the ACR's views on physician ownership of referral imaging centers and radiation oncology centers.

I also note that the crowd of people interested in this issue has grown. A few years ago, when you held the first hearing on this issue, we were almost alone with you in the room. I am also pleased that others now have concerns about the growing incidence of physician ownership and the implications it has for our health care system.

Here today is also another diagnostic radiology and a radiation oncologist from Florida, here to give their individual perspective on physician ownership and self-referral.

It is our position at the ACR that physicians should not have a direct nor indirect financial interest in diagnostic or therapeutic facilities to which they refer patients. Further, we support legislation which would eliminate this conflict of interest by prohibiting such ownership arrangements in health care.

Referral physician ownership of health care facilities is an issue that appropriately should be addressed within medicine, but, unfortunately, this has not been done, and so it is critical that it be addressed legislatively.

We can no longer wait for the problem to correct itself, nor can we wait for enforcement of current law to correct the problem.

We have long held at ACR that these financial arrangements lead to inappropriate utilization of medical services, and that the justification for development of these arrangements is contrived. We do not believe that joint ventures, which include referring physicians, have proliferated because of a need to increase access to care or to achieve economies of scale in providing health care services.

These arrangements are intended to capture and control the market for a given set of health care services, and this control does not benefit patients or payers.

The Florida study states that where referring physician joint ventures exist, the normal economic forces of competition do not apply. We believe that this market control has led to increased utilization and higher prices, which generate large profits. Quality is eliminated as a factor in competition.

Some have argued that referring physician ownership need not be addressed in legislation, because the practice is not widespread. This is not the case. The Florida study shows the extent of physician ownership in health facilities, and it far exceeds our previous predictions. No one can claim that this is not a widespread problem.

In Florida, at least 40 percent of physicians involved in direct patient care are involved in joint ventures to which they can refer patients. This fact, coupled with higher utilization rates and higher charges for these referring physician owned facilities, is convincing evidence of the result of unbridled referring physician involvement in health care facilities. We do not believe it is necessary to wait until the problem has reached epidemic stages nationally, before reining in these arrangements.

We would oppose these financial arrangements, even if only a few physicians were involved, but abusive activities by a few physicians should not be condoned, any more than the abusive activities of many.

Those who support the continuation of financial arrangements among physicians have argued that these ventures are necessary to assure access to services in underserved areas. We doubt that the predominant reason for joint ventures is to provide access to services in rural or underserved areas.

A second point to be made in regard to access is specifically addressed to the argument that health services would be unavailable, without using referring physicians as a source of capital for these facilities. We do not believe this to be the case.

Most often, referring physicians' participation in these joint ventures involves only signing a note for debt, and not in providing capital for the facility. If, in fact, an area in the country finds that lack of capital is restricting access to services, a clear exception could be made, when there is concrete evidence that the referring physicians involved are actually providing the needed capital for the facility.

The issue of physician ownership has only been partly addressed by the publication of "safe harbors" by the Inspector General of HHS. While these regulations address the most egregious of common arrangements, they go only as far as current law allows.

We believe that the issue of referring physician ownership in medical facilities should be clarified in law by preventing such ownership. We also believe that it is time that other organizations representing physicians take a definitive stance against these arrangements, which jeopardize the confidence that patients have had in their physicians.

Thank you.

[The prepared statement follows:]

Testimony of the American College of Radiology
to
The Sub-committee on Health
House Ways and Means Committee
by
James M. Moorefield, M.D.
October 17, 1991

The American College of Radiology is pleased to present the following statement on the issue of physicians' ownership in health care facilities to which they refer patients.

The ACR believes that physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients and we support legislation which would eliminate this conflict of interest by prohibiting such ownership arrangements in health care.

We believe that referral physician ownership of health care facilities is an issue that appropriately should be addressed within medicine, but since this has not been done, it is critical that it be addressed legislatively. There is increasing evidence that this practice is adversely affecting patient care and adding to the cost of health care in the United States. The study by the State of Florida Health Care Cost Containment Board provides such evidence. We have examined some of the raw data entering into that study and confirmed that the great preponderance of imaging centers in Florida are partly or wholly owned by referring physicians. We can no longer wait for the problem to correct itself, nor can we wait for enforcement of current law to correct the problem.

We have long held that these financial arrangements lead to inappropriate utilization of medical services and that the justification for development of these arrangements is contrived. We do not believe that joint ventures which include referring physicians have proliferated because of a need to increase access to care or to achieve economies of scale in providing health care services.

We believe these arrangements are intended to capture the market for a given set of health care services and that this control does not benefit patients. The Florida study states that where referring physician joint ventures exist, the normal economic forces of competition do not apply. We believe that this market control has led to increased utilization, higher prices and lower quality which generate unmandated large profits.

We are also concerned about the resultant exploitation of referral-dependent physicians as referring physicians band together to exercise market control and by subterfuge, demand a portion of the practice income of the consulting physicians in return for referrals. The practice of physicians seeking compensation for this market control of patient referrals is pervasive and we believe any doubt as to the impropriety of these actions, ethically, legally or morally, should be eliminated.

ACR Policy

The current position of the American College of Radiology is based on our members' experience with such financial arrangements. As these joint ventures proliferated in the early 1980's, the ACR debated the merits and disadvantages of these arrangements. In 1984, our policy-making council initially adopted the position that radiologists could ethically participate in financial arrangements, such as joint ventures, in order to provide diagnostic and therapeutic care to patients. But our position also warned our members of the potential for abuse in financial arrangements that involved referring physicians. With that caution, we believed that financial arrangements to fund imaging centers and radiation oncology centers could be structured to avoid conflict of interest, fraud, and abuse of patient confidence.

We found we were wrong. In 1988, our council reconsidered this position. In those four years between 1984 and 1988, we found that the potential for, and actual abuse and exploitation of patients by unethical practices, and the flagrant disregard of physicians' ethical responsibilities to the patient to be so great and so pervasive that these arrangements could not be ignored. We adopted a new policy statement:

"The position of the American College of Radiology is that the practice of self-referral of patients for a diagnostic or therapeutic medical procedure may not be in the best interest of the patient. Accordingly, referring physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients, and that the American College of Radiology supports legislative efforts prohibiting reimbursement for any diagnostic or therapeutic procedure carried out in a facility in which the referring physician has a direct or indirect financial interest."

Extent of the Problem

Some have argued that referring physician ownership need not be addressed in legislation because the practice is not widespread. We know this not to be the case. Recently released studies, such as the one conducted by the State of Florida, show the extent of physician ownership in health facilities and it far exceeds our predictions. It can no longer be claimed that this is not a wide spread problem.

As reported, the Florida study shows that at least 40 percent of physicians involved in direct patient care are involved in joint ventures to which they can refer patients. This fact, coupled with the higher utilization rates and higher charges for these referring physician owned facilities, is convincing evidence of the result of unbridled referring physician involvement in health care facilities. Those that claim that national numbers are far below those in Florida are ignoring the trend. We do not believe it is necessary to wait until the problem has reached national epidemic stages before reining in these financial arrangements. Medicare's BMAD data show the use of CT scanning and magnetic resonance imaging in Florida are well above national levels, and so are charges. It would not be wise to wait for a Florida-like pattern to become typical of the nation.

We must oppose these financial arrangements even if only a few physicians were involved. Abusive activities by a few physicians should not be condoned any more than abusive activities of many.

Access to Care

Those who support the continuation of financial arrangements among physicians have argued that these ventures are necessary to assure access to services in underserved areas. We doubt that the predominate reason for joint ventures is to provide access to services in rural or underserved areas. A major conclusion in the Florida study was that "joint ventures do not increase access to rural or underserved indigent patients." We believe that further study will support this finding.

A second point to be made in regard to access is specifically addressed to the argument that health services would be unavailable without using referring physicians as a source of capital for these facilities. We do not believe this is the case. Most often, referring physicians participation in these joint ventures involves only signing a note for debt, not in providing capital for the facility. If in fact, an area in the country finds that lack of capital is restricting access to services, a clear exception could be made when there is concrete evidence that the referring physicians involved are actually providing the needed capital for the facility. We do not believe that these joint ventures are created because "there's no money in town."

Self-referral of Patients

While we support legislative efforts to prohibit referring physicians' financial involvement in health facilities, we must urge your caution in developing the legislation. If facilities currently in operation may simply declare themselves as extensions of group practices or private physician offices, the intent of the legislation will have been circumvented because referring physicians will continue to self-refer. The problem with increased utilization in referring physician owned facilities will be simply changed to a problem of increased utilization of services within physicians' offices.

Allowing physicians to refer patients to themselves raises two issues. First, in many cases, these physicians may be performing examinations for which they have received little or no training to either perform or interpret. If this involves complex radiologic procedures, it is more egregious than the prevalent questionable practice of self-referral of standard radiologic and laboratory procedures.

The second issue in this practice of self-referral is the potential for increased utilization of radiologic procedures. The issue of self-referral of patients for health care services was the focus of a scientific paper published on December 6, 1990 in the *New England Journal of Medicine*. We have previously submitted this article for your review and consideration. Other studies are currently underway which will provide further data on the impact of self-referral, including an assessment of quality of care.

We do not believe that any legislation should create an incentive or circumstance where services are provided by untrained or unskilled physicians, who are either unconcerned with or unaware of proper practice standards. In the best interest of patients, we should assure access to medical care from physicians qualified to provide the service.

Conclusion

In this era of antitrust sensitivities and litigation, voluntary organizations such as the ACR can set standards and urge compliance, but we cannot mandate behavior of radiologists. Nor can we mandate the behavior of others in the health care system. We recognize that many of these practices arise from the pressure of the highly competitive health care marketplace, but under no circumstance should competition lead to the acceptance of exploitive and unethical practices.

The issue of physician ownership has only been partly addressed by the publication of "safe harbors" by the HHS Inspector General. While these regulations address the most egregious of common arrangements, they go only as far as current law allows. We were delighted with the outcome of the HHS Departmental Appeals Board decision in the Hanlester Network case. But, Safe Harbor regulations and the Hanlester decision have already generated substantial effort on the part of many to simply restructure financial arrangements to meet the new rules. We will watch with interest the enforcement of the anti-kickback law by the OIG.

We believe the issue of referring physician ownership in medical facilities should be clarified in law by preventing such ownership. We also believe that other organizations representing physicians must take a definitive stance against these arrangements which jeopardize the confidence that patients have in their physicians.

Chairman STARK. Thank you.
Dr. Isikoff.

STATEMENT OF MICHAEL B. ISIKOFF, M.D., STAFF RADIOLOGIST, PARRISH MEDICAL CENTER, TITUSVILLE, FLA.

Dr. ISIKOFF. Congressman Stark, Congressman Pickle, members of the House Ways and Means Committee, ladies and gentlemen: My name is Dr. Michael Isikoff. I am a physician specializing in radiology in private practice in a small community outside Orlando, Fla.

I appreciate the opportunity to address you today on the issue of joint ventures.

If left unchecked, physician self-referral has the potential to completely destroy the trust necessary for the doctor-patient relationship to exist. When doctors refer patients to facilities in which they own a share, there arises a potential conflict of interest between what is good for the patient and what is good for the doctor's bank account. Even if the service is necessary and the quality of service remains high—and there is some doubt that this is always the case—the healthy competition necessary to keep costs down cannot exist in such an atmosphere.

I speak from personal experience. Nine years ago, the successful radiology office that my partners and I had established in suburban Orlando was abruptly put out of business by the formation of a joint venture by physicians who had previously referred patients to us and other competing facilities. It was neither quality nor cost that did us in, as the physicians readily admitted.

Rather, it was the desire to increase their own income by adding the revenues from imaging studies that they recommended for their patients. A family practitioner who had been one of our biggest referrers put it to me this way:

> The facts of life are that the patients belong to me, I control them, they will do whatever I say, and go wherever I send them for x rays. I'm no longer going to send them to you, unless I get something in return. You will work for me at whatever I choose to pay you, or you will not work at all.

Unfortunately, he was right. Within 2 weeks, we were basically out of business. By controlling the patient, the demand for the service and the service itself, the doctors produced a vertical monopoly. In any other industry, this would be illegal. Yet, today, joint ventures of this sort can be found in nearly every State.

In my own State, according to the recent study by the Florida Health Care Cost Containment Board, which you just heard about, virtually all outpatient diagnostic imaging centers are joint ventured, and at least 40 percent of the State's physicians have ownership interests in facilities to which they can refer patients.

These physicians and the organizations which represent them will tell you that there are many advantages to joint ventures beyond increasing their own incomes. The Florida Medical Association states that they "increase access to health care by improving geographic distribution of services and by enhancing the competitive environment in which these services are offered."

With regard to "improved geographic distribution," the Florida HCCCB study found that there are no joint ventures in rural or underserved areas of the State, but they were almost exclusively concentrated in large metropolitan areas. And if by access, one means the availability of the service to all patients, then joint ventures again fail the test. Virtually none of the ventures in Florida accept Medicaid patients, and, as a result of the recently published "safe harbors," more and more of them are dropping Medicare patients, as well.

With regard to the "enhanced competitive environment," we have already discussed my personal experience, but what does the data from Florida show? An independent analysis by the Center for Health Policy Studies finds that the average cost of a magnetic resonance imaging scan in the State of Florida is among the highest in the Nation. In a truly competitive environment, costs are reduced, not increased. When the increased price per test is compounded by the overutilization documented in the Florida study and elsewhere, the overall cost to the health care system is astronomical.

But cost is not the only issue. Many people are willing to pay more when they are assured of superior quality or convenience. I know of a mammography center that charges $110 per exam, while the price at a nearby competing facility is $55. For $110, a woman gets a mammogram performed by a technician in a nonaccredited facility, with a several-day delay before initial results are reported, and further weeks of delay if she needs to be recalled for additional views or better quality films. The delays are caused by the fact that there is no physician on site to monitor the study. The films are sent out of town to be read.

In contrast, at the competing facility down the street, for $55, the patient gets a screening mammogram at an ACR accredited facility with an onsite radiologist who can immediately obtain additional views as required, and who issues his report the same day. The woman is not inconvenienced by the need for additional appointments and lost work days. More importantly, she has her results quickly.

So, why is there a 3-week waiting list at the $110 facility? Ask the physicians who own it. When the patients ask, they are told that the equipment is better in that facility or the interpretation is better in that facility. Furthermore, if they do not go where their doctor recommends, they should find themselves another doctor.

The only truth in that statement is in the third part. Patients whose doctors put their pockets ahead of their patients should definitely find themselves another doctor.

Can I go on?

Chairman Stark. Please.

Dr. Isikoff. Joint ventures are successful, because, as that family practitioner told me 9 years ago, the doctors control their patients. It is a rare patient, indeed, who will ever question their own doctor's judgment on the need for a particular service, and where to go for that service.

Even if the doctor informs the patient of his financial interests, as is required by law in many States, the patient will almost always go where the doctor tells him. But it is not only the patient who may be controlled in this fashion. Medical specialists who depend on primary physicians for referrals have been coerced into supporting a particular facility, because they fear losing those referrals. In many cases, specialists who once practiced independently have been forced to joint venture their existing offices, in order to survive.

Physician-owned joint ventures are bad for medicine. As the public becomes increasingly aware of these conflicts, what will happen to the trust they have always placed in their personal physicians? That trust is the foundation of the doctor-patient relationship. Overpriced and overutilized services will continue to adds to the soaring costs of medical care, without any improvement in access or quality.

As long as doctors continue to view their patients as commodities on which they can make money, and as long as organized medicine continues to deny the existence of a problem, there will be no meaningful action from within to correct it. This action must come from you.

I am here today to implore Congress to pass legislation to eliminate this abuse.

Thank you.

Chairman STARK. Thank you very much, Dr. Isikoff.

If one of our colleagues does not return by about 3 or 4 after the hour, I will recess for a few minutes, but I think somebody will be back and you can proceed.

Mr. Carl.

STATEMENT OF ROBERT D. CARL III, PRESIDENT, CHAIRMAN, AND CHIEF EXECUTIVE OFFICER, HEALTH IMAGES, INC., ATLANTA, GA.

Mr. CARL. Thank you, Mr. Chairman.

My name is Robert D. Carl III. I am president, chairman, and chief executive officer of Health Images, Inc.. Health Images is a public company that owns 30 MRI centers located in 10 States—Georgia, Florida, Illinois, Maryland, New Jersey, Oklahoma, Pennsylvania, South Carolina, Tennessee, and Texas. Last week, we opened our newest center in Austin.

We are the largest owner-operator of such centers in the United States.

I am appearing here today at great risk to my company. You have heard from the last panel about the impact of self-referral in Florida. Our Florida centers participated in the study, and we have testified twice in Florida in support of the joint venture study.

As a result of our testifying before the Florida Health Care Cost Containment Board, we have been threatened with a boycott by physicians in a Florida city. One physician has said that he will urge members of the local medical society to stop referring patients to our center, because we support a ban on self-referral of MRI patients to physician invested centers. Just this week, I learned that another boycott is taking place at one of our Georgia centers.

Health Images has a unique perspective on the practice of physician self-referral to MRI centers. When we started Health Images, we had physician investors. Such investors were generally required for financing a project by banks and other lenders. We quickly learned, however, that physician investors impeded our providing high-quality health care services.

In 1988, we decided to develop all future centers without physician investors and to buy out remaining physician investors. Thus, we have experience operating MRI centers with and without physician investors, and we have found the following:

First, we have found excessive utilization at physician invested centers. A legitimate percentage, approximately 25 percent, of MRI scans will be negative. When we bought out physician limited partners at one center, we examined patient records to determine the negative rate prior to buyout. It was 50 percent or twice what would be expected. This finding is confirmed by the Florida study.

Second, physician investors often told us they did not care what we charge or how good our service is. They told us on frequent occasions that they were ceasing referrals to our centers, because their partnership distributions were too low. At one center, patient referrals dropped from 13 to 7 per day, as physician investors expressed their anger at us for not distributing more money, even though at that center all available free cash-flow was promptly distributed to partners.

We have found many physicians failing to understand that distributions were limited by the profits and free cash-flow of the centers. They always wanted more distributions, even if no profits were earned. In our view, such demands constituted a request for kickbacks.

Third, when we purchased expensive upgrades to the MRI equipment at our joint venture centers, physician investors frequently complained that, instead of making such investments in quality enhancements, we should have made larger cash distributions to them.

Fourth, we have reviewed numerous prospectuses offering investments in MRI centers to physicians. Generally, these investments are limited to referring physicians located in the same geographical area as the center. I believe many of these arrangements are shams. Nominal investment amounts, sometimes as low as $500 in cash, are solicited by unscrupulous entrepreneurial promoters of these schemes in a thinly disguised attempt to purchase referrals from the investing physicians.

The balance of the investment is nothing more than a promissory note signed by the investing physician to repay the balance of his capital contribution from future distributions from the venture. These notes are usually nonrecourse and noninterest bearing. In return for the $500 in cash and the note, investing physicians are promised annual returns of staggering proportions. I have seen some as high as 1,200 percent. Long-term Treasury bonds presently yield less than 8 percent per annum. A 20-percent return on equity would be considered superior for a public company.

Clearly, these deals are not real investments.

I might point out, these are generally riskless investments. They are, as you have stated on many occasions, Mr. Chairman, the purchase of referrals. While most physicians are ethical practitioners of their profession, physician investment in imaging centers creates incentives for overutilization. The Florida study, which confirms our experience, graphically illustrates the excessive costs generated by self-referral. Medicare should not be paying for these services nor funding these perverse incentives for overutilization.

Let me close by making two final points: First, self-referral of MRI services is not necessary to assure access to the technology. We would be delighted to open an MRI center in any locality where legitimate demand is sufficient. So would the local hospital.

Second—and I cannot emphasize this enough—the Florida experience is not unique. We see egregious and rampant self-referral in all of our markets. This is as national problem.

Thank you.

[The prepared statement follows:]

STATEMENT OF HEALTH IMAGES, INC.
TO THE HEALTH AND OVERSIGHT SUBCOMMITTEES
OF THE HOUSE WAYS AND MEANS COMMITTEE

Health Images, Inc. (hereinafter "Health Images" or "the Company") greatly appreciates the opportunity to testify on the effect of physician investment in ancillary health care providers. Health Images is a publicly-held corporation, headquartered in Atlanta, Georgia, specializing in the establishment and operation of free-standing magnetic resonance imaging centers ("MRI centers"). The Company currently operates thirty centers in ten states and one in the United Kingdom. Health Images expects to open another new center before the end of 1991.

Health Images has a unique perspective on issues related to physician investment in health care facilities. When Health Images began in 1984, MRI was a relatively new and little understood technology. As a result, in order to gain acceptance among physicians in a community and in order to obtain financing, it was often necessary to have physician investment. Therefore, when Health Images began, it, like most other MRI providers, formed joint ventures with physicians as limited partners. These ventures complied with all then-applicable state and federal laws.

As Health Images gained greater experience in the field, however, it quickly learned that physician investment actually impeded, rather than facilitated, the provision of high quality MRI services. As a result, since mid-1988, Health Images has operated without physician limited partners in its new facilities and has repurchased almost all of the limited partnership units that it previously sold. We have purchase offers outstanding on the few remaining limited partnership shares.

Given Health Images' own history, we read with great interest the results of the Joint Venture Study conducted by the Florida Health Care Cost Containment Board ("HCCCB") in conjunction with Florida State University. In reviewing this study, two primary conclusions are obvious. First, physician investment in ancillary health care facilities pervades the entire health care system, including the health care system in Florida. Second, when physicians engage in "self-referral," i.e., refer to entities in which they also have a financial interest, their treatment decisions are likely to be affected by that interest and their utilization of the services offered by that facility is likely to increase.

Neither of these conclusions is especially new or surprising. The extent of physician investment in ancillary providers has, of course, been the subject of great study and debate in recent years. Moreover, it would be surprising if physicians' utilization patterns were not affected by their investments. As Dr. Arnold Relman, former editor of The New England Journal of Medicine, stated in a recent interview: "Doctors are ordinary people [and] are no more or less impervious to economic incentives than anybody else."[1] Finally, these conclusions are wholly consistent with Health Images' own experience, both at the time that we had physician investment and since we have repurchased those shares.

In our statement today, we would first like to detail some examples of the impact of physician investment based on our own experience and observation. We would then like to discuss the conclusions of the HCCCB study in Florida. Finally, we would like to discuss why legislation to curb self-referral is so vitally needed.

A. Health Images' Own Experience With Physician Investment

Health Images' own experience supports the view that physicians' investment interests affect their decisions about whether to order an MRI, and, if so, from whom to order it. Because, in most instances, an MRI facility cannot perform an MRI without a physician order, all MRI providers require physician patronage. Indeed, as a result of the crucial role played by physicians in ordering MRI services, Health Images is taking a substantial risk merely in testifying here today. In fact, as the Company's involvement in this issue has become more widely known, some physicians have explicitly told us that they will no longer refer patients to our facilities and that they will urge other physicians to do the same. We believe very strongly, however, in the correctness of our position and in the need for effective legislation to eliminate the practice of self-referral.

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[1] "Marketplace," Nat'l. Pub. Radio, broadcast June 17, 1991.

The problem with self-referral is that it forces physicians to consider their own economic interests along with the interests of their patients. This circumstance, in turn, leads to increased utilization of services, inflated costs and a loss of the benefits that usually flow from a competitive market. Health Images has seen evidence of the negative impact of self-referral everywhere that the Company does business. For example, during the period that the Company had physician-investors, physicians often stated that they would only refer to our centers if they were given an opportunity to invest in them and earn a profit on their referrals. One physician explicitly told Company representatives that he would need "a little tickle" to refer his patients to the Health Images center. In another instance, a large orthopedic group stated that they would send one of the Company's centers as many as 300 patients a month--a tremendous number--if the Company would arrange for certain all-expense paid trips to Mexico for partners in the group. Finally, physicians also frequently told Health Images marketing representatives during this time that they were not interested in the quality of Health Images' services as they would not refer to one of our centers because they were already invested in another center. Clearly, these examples all demonstrate that physicians were interested in something in addition to welfare of their patients.

Moreover, when physicians were invested in a Health Images facility, they would often threaten to withhold, or actually withhold, patients if they were displeased with the size or timing of their partnership distributions. In one instance, for example, patients at one of our centers dropped from a high of 13 per day to about 7, because the physician-investors were angry about the amount of their partnership distribution. Further, once the Company bought out the physician-investors at this center, these physicians never referred another patient to the facility. Apparently, they were only willing to use our center so long as they had a financial interest in it.

Further, while the argument is often made that physician investment helps insure quality, this was certainly not our experience when we had physician investment. Physicians seldom expressed an active interest in the quality of the services provided at our centers. They were usually far more concerned with the size of the returns on their investment. In several instances, physicians actually objected to the Company's spending money for routine equipment upgrades to enhance the quality of its scans. They argued that such improvements were unnecessary and that the funds could be better used to increase the returns on their investment.

Our experience also supports the conclusion that physician investment leads to increased utilization. The best way to measure whether excess utilization is occurring at an MRI facility is to examine the percentage of scans that are negative, that is, where no abnormality is found. Obviously, because MRI is often used to exclude the existence of certain conditions, some percentage of MRI scans will always be negative. In most of our centers, negative scans average about 25 percent of the total. However, after the Company completed a buy-out of physician-limited partners at one center, we examined patient charts to determine the negative rate during the time that we had physician-investors. We found the negative rate among certain physician-investors was approximately 50 percent, or twice what we expected, thereby suggesting that many patients were being referred for unnecessary procedures.

Because of these and similar experiences, in mid-1988 Health Images made the decision to stop establishing limited partnerships with physicians. All of our new MRI centers are wholly owned by Health Images. Further, the Company has repurchased almost all of the physician partnership interests that it previously sold. As a result, Health Images believes the quality of its services has improved, because we cannot depend on captive referrals and must devote our time and energy to fulfilling the needs of patients.

Because of its decision, however, Health Images is still at a significant disadvantage because the Company must compete with physician-owned centers. Our marketing representatives still are frequently told by physicians that they are not interested in the quality of Health Images' services because they are already invested in another MRI center to which they refer their patients. Thus, regardless of the high quality of the services offered by Health Images (or, in some instances, the lesser quality of the services offered by the competing center), these physicians simply will not refer to a Health Images facility.

Indeed, we are aware of one case in which the physician refused to refer a patient to one of our centers even though the patient specifically asked to go there. In this instance, the physician had invested in a competing MRI center where the MRI machine was housed in a large trailer. A female patient expressed concern to this physician because she suffered from claustrophobia and feared undergoing an MRI in the trailer's cramped quarters. Because an MRI requires the patient to lie in a very small, enclosed space for a long period, it is not unusual for patients to express such anxieties. This particular patient told her physician that she wished to go to the Health Images facility, which was larger, close-by and located in a free-standing building. However, the physician would not refer the patient to our center and stated he would refuse to treat her any longer if she insisted on going there.

Further, Health Images is at a significant disadvantage in competing with these physician-owned centers because they offer their physician-investors the opportunity to earn tremendous returns on very limited investments. One prospectus for an MRI facility that Health Images recently obtained specifically explained to prospective physician-investors how their returns would increase, depending on the number of referrals per partner.[2] It showed:

	Annual Share of Income per partner
15 limited partners	
3 referrals p/wk per partner	$29,080
4 referrals p/wk per partner	$46,240
20 limited partners	
3 referrals p/wk per partner	$34,680
4 referrals p/wk per partner	$51,000

The obvious implication of these figures is that the more patients a physician refers, the more money he can earn. If these are the annual returns based on referrals of three or four patients a week, one can only guess at what they would be if there were referrals of five or six patients a week. Moreover, these returns were earned on an initial investment of $10,000, only half of which had to be in cash. The other half was loaned to the physician by the joint venture itself in exchange for an interest-free, promissory note.

Nor is the situation detailed above unusual. In the Houston area there is a network of physician-owned MRI and CT centers, all of which are managed and operated by the same individual, a practicing neurologist in Texas. This doctor usually acts as general partner, either individually or through a corporation he manages. The most recent prospectus that we have seen shows that this one physician is the general partner in at least 12 other diagnostic imaging centers in the Houston area. In addition, he has reportedly established another center in Illinois and is also looking to expand into other states. He is a partner in two diagnostic medical groups as well. All of these centers also have a large number of physician-limited partners.

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[2] No doubt because of the obvious implications of such statements under the Medicare antikickback law, the prospectus specifically states that the proposed center will not serve Medicare and Medicaid patients.

Nor is it difficult to see why physicians would wish to invest in this physician's centers. The prospectus for one of his centers offered investors a return of over 1200 percent in just the first year on a per unit investment of $5500, of which only $500 was in cash. The remainder of the capital contribution was borrowed from the joint venture to be paid back out of future profit distributions. The other centers were structured in similar ways, although in some instances the projected returns were lower--only 580 percent to 960 percent in the first year.

Moreover, as these examples suggest, the purpose of such arrangements is not to raise capital. In fact, in the prospectuses that Health Images has seen, the limited partners' contribution represents a very small percentage of the necessary start-up capital. Indeed, as noted above, often the investors do not even contribute cash for their shares. In fact, most of the initial capital for the venture--often more than two-thirds--comes from some form of long-term financing. Obviously, these limited partnerships are not real investments. If the purpose of such arrangements were truly to raise capital, the right to invest would not be limited, as often happens, to licensed physicians, to physicians licensed to do business in the state where the venture is located, or to physicians with staff privileges at the hospital affiliated with the venture. Clearly, such restrictions are inconsistent with a true desire to raise capital.

That these arrangements actually have some other purpose is dramatically illustrated by a situation reported in a recent New York Times article on self-referral.[3] In that instance, a group of physicians formed a limited partnership which obtained an MRI machine that it then leased to the hospital where the physician-investors practiced. In fact, the limited partnership was, at least initially, open only to physicians who had staff privileges at the hospital. Moreover, under the terms of the original lease between the partnership and the hospital, the rent paid to the physicians from the hospital increased as the number of scans increased. Because the physician-investors were also the ones referring patients, they could, therefore, increase their own return simply by referring more patients.

That this convoluted arrangement was unnecessary is obvious when we consider the alternatives. The hospital could simply have leased or purchased the MRI machine directly from a supplier of MRI equipment, without the physicians' acting as middlemen. As the hospital in question is operated by the County Hospital Authority, it could probably have borrowed at highly favorable rates if necessary. Naturally, it would also have received the income from the use of the machine. Or, if it wished, the hospital could have leased land or space to an independent MRI provider, such as Health Images, which would have provided the services. In this way, the hospital's patients would have received the necessary services; the hospital would have received the rental income; and none of the hospital's own capital would have been tied up. In short, the actual structure of the deal suggests that it had little purpose other than to ensure that the physician investors had an opportunity to earn a significant return on their investment.

Finally, in our experience, it is also not true that such ventures increase access to MRI services for those who otherwise would not have it. First, there are a number of providers, including Health Images, ready and willing to come into an area that is in need of MRI services. Further, in Health Images' experience, few of these partnerships are located in rural or medically-underserved areas, a conclusion that is supported by the Florida Joint Venture Study. See Joint Venture Study, Vol. II at v. In addition, the prospectuses for many joint ventures specifically state that the venture will not even accept Medicare or Medicaid patients. These operations prefer to concentrate on more lucrative private-pay patients. In sum, there can be little question that self-referral has a variety of serious, adverse effects on the delivery of health care services.

3/ R. Pear & E. Eckholm, "When Healers Are Entrepreneurs: A Debate Over Costs and Ethics," N.Y. Times, June 2, 1991, at A1.

B. The Florida HCCCB Study

The recent Joint Venture Study conducted by the Florida HCCCB also graphically demonstrates the adverse effects of self-referral on utilization and costs. In addition, these conclusions are further bolstered by an independent study of Florida MRI utilization and costs done by the Center for Health Policy Studies, of Columbia, Maryland. Both of these documents strongly argue in favor of a curb on self-referral in diagnostic imaging.

The Florida Joint Venture Study attempted to survey all providers of ancillary health care services in the state. It found that 93 percent of diagnostic imaging centers returning surveys had physician-investors. Only one center providing MRI services--a Health Images facility--did not have physician-investors.[4] Because of the small number of non-physician-owned centers, it was impossible for the authors of the report to compare utilization in Florida at joint venture and non-joint venture facilities. However, they did find that utilization was higher in several Florida metropolitan areas than it was in Baltimore, which is demographically similar. Finally, the authors found higher "reward-to-risk" ratios for diagnostic imaging centers than for any other type of facility covered by the survey, which suggested that these centers were also charging excessive prices. Based on this evidence, at its most recent meeting, the staff of the HCCCB recommended to the Board that it call for the prohibition of self-referral in the case of diagnostic imaging and certain other services, where abuse was clearly shown.

Not surprisingly, Health Images finds itself in agreement in nearly every respect with the conclusions expressed in the two volumes of the Florida Joint Venture Study. Indeed, we believe our experience gives us a unique perspective on the data offered in the report. We would, therefore, like to offer several observations on the information presented there.

First, Table 4.1 and 4.2 of the study both show that MRI facilities in Florida perform scans on approximately 2,730 outpatients per year. Based on 250 business days a year, which is standard for such projections, this constitutes almost 11 patients a day on average. This is extraordinarily high utilization. A study of MRI utilization rates conducted by the American Hospital Association showed that hospital centers averaged about 1,769 "billable" scans per year, which is only about seven per day.[5] Most established Health Images centers average about 9 per day and new ones average around 5 per day. For centers in Florida to be this busy on a consistent basis clearly suggests that physician investment is leading to increasing utilization.

Indeed, the level of utilization shown is especially high given the large number of MRI machines located in the state during the time covered by the survey. Tables 4.1 and 4.2 suggest that there are at least 39 joint venture facilities, some of which appear to have more than one MRI machine.[6] In addition, in 1989, there were at least 48 MRIs located at hospitals in Florida.[7] Thus, there were at least 87 machines performing MRIs during the time covered by the survey. Moreover, the report acknowledges that responses were not received from some joint venture entities.

This is a large number of centers to keep busy at such a high rate. The utilization also appears high when we realize that Canada, with a population more than twice that of Florida, had only 12 MRI machines in 1988. West Germany, in 1987, had only 57 MRI machines, about two-thirds the number in Florida; but West Germany had a population five times that of Florida.[8/]

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[4] Health Images now has three centers in Florida. During the time period covered by the study, we had only two centers there, one of which still had physician-investors.

[5] Hoppszallern, MRI Utilization Model: Results of a Validation Study, Hospital Technology Series: Special Report (American Hosp. Ass'n, Mar. 1990).

[6] We assume this because both Tables 4.1 and 4.2 show MRI procedures per facility that are slightly higher than the MRI procedures per machine.

[7] American Hospital Ass'n, Hospital Statistics (1990-91) at 48.

Health Images believes the Joint Venture Study's conclusions are fully supported by the data presented. However, because of some criticism leveled at the report, Health Images requested Dr. Zachary Dyckman of the Center for Health Policy Studies (CHPS), a broad-based health care research and consulting firm in Columbia, Maryland, to perform his own comparison of MRI and CT utilization and costs in Florida with that in other states. Copies of Dr. Dyckman's report have been furnished to the staff of the Subcommittees. Dr. Dyckman made his analysis using information from Blue Cross and Blue Shield plans and from the Medicare BMAD file. Overall, Dr. Dyckman found that the charges and utilization were significantly higher in Florida than in other states participating in the study. Based on his analysis of Medicare data, he found:

- Florida ranks 4th highest among 48 states for which data was available in number of MRI tests per 1,000 beneficiaries. The Florida MRI utilization rate is 45 percent above the national average.

- Total MRI charges measured on a per beneficiary basis (which includes effects of volume and price) are 55-65 percent greater in Florida than the national average.

- Volume and total charges for MRI tests performed in just non-hospital imaging centers (virtually all of which are joint ventures in Florida) are, respectively, 118 percent and 92 percent greater than the national average. The charge and utilization experience for MRI tests performed in the hospital setting, however, are very close to national experience.

Dr. Dyckman stated that it was reasonable to infer that "a significant causative factor for the higher Florida utilization and cost experience is the large number of imaging joint ventures in which physicians have financial incentives to refer patients and increase the number of referrals."

In sum, there is little question that the high level of physician investment in Florida has led to increased costs and utilization of diagnostic imaging services.

C. The Need for Legislation

Health Images believes that data presented above confirms that the practice of self-referral threatens our entire health care system. It drives up health care costs by encouraging overutilization and forces patients to endure unnecessary health care procedures. Further, it makes it impossible for independent MRI providers--like Health Images--to compete effectively, regardless of the quality of their services or the competitiveness of their prices. As a result of this practice, almost everyone involved--providers, payors and especially patients--are losers. The only winners are those physicians who are allowed to invest in these deals.

We believe that it is vitally important that legislation be enacted making it illegal for physicians to refer their patients to diagnostic imaging facilities in which they have an ownership or investment interest. We believe our own experience, the data presented in the Florida Joint Venture Study and Dr. Dyckman's analysis all demonstrate unequivocally the need for such legislation. Moreover, we expect that the cost to Medicare of self-referral in diagnostic imaging is likely to be far more than the cost of self-referral in the clinical laboratory industry was projected to be when Congress prohibited it in 1989. We believe it is essential to now extend that prohibition to diagnostic imaging.

We understand that some have argued that the recent promulgation of the safe harbor regulations and the HHS Departmental Appeals Board decision in OIG v. Hanlester Network make such a prohibition unnecessary. Health Images does not agree. The safe harbors do immunize physician investment in facilities to which the physicians also refer

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[8/] Rublee, Medical Technology in Canada, Germany, and the U.S., Health Affairs 178 (Fall, 1989). U.S. Dept. of Commerce, Statistical Abstract of the United States, 24, 831 & 833 (1990).

in certain situations, but other situations not meeting the terms of the safe harbor are not illegal. They simply must be decided on a case-by-case basis. Similarly, the Hanlester decision, which will almost certainly be the subject of further appeals, does find that in the situation presented in that case, self-referral violated the Medicare antikickback law; but the legal standard established is still quite ambiguous and subject to varying interpretations.

Neither of these two developments is likely to end the phenomenon of self-referral, especially given the tremendous returns that are offered to physician-investors. We expect that many physician joint ventures will simply ignore the safe harbors and the Hanlester decision, and continue to operate as they have in the past, secure in the knowledge that the small staff of the OIG will be unable to ferret out any but the most egregious violations. In addition, Medicare should not be asked to pay for unnecessary services or fund the perverse incentives that self-referral spawns. If the evils of self-referral are truly to be eliminated, a single, clear "bright line" standard is necessary, one which is not subject to complicated interpretation or easy evasion. We urge you to enact such a prohibition.

Health Images has always tried to furnish high quality MRI services at a fair price. However, in a market dominated by self-referral, the high quality of our services and the reasonable price at which we offer them are meaningless. Unfortunately, because of their investments, physicians are often more interested in the size of their returns than in the quality or price of the services offered to their patients. As a result, the utilization and costs of the services increase and the other benefits that should flow from healthy competition--higher quality, better service, and increased efficiency--are lost. For all these reasons, we urge you to prohibit Medicare reimbursement for self-referred MRI services.

Chairman STARK. Thank you, Mr. Carl.

I think that this would be a good time to recess briefly, while I go to vote, and the first member who returns may choose to inquire. While I am gone, you might all think carefully about where some of these investments are available for less than $500 in cash, unlimited nonrecourse notes, as long as they are limited partnerships that I could buy. I would like roughly a dozen. If you could think of a hundred, I would like a hundred. I will even give you a check that will not bounce. [Laughter.]

So, I will see you all in a few minutes.

[Recess.]

Chairman STARK. The hearing will resume.

I am afraid we are going to be interrupted fairly frequently with votes, but we will try and move along as quickly as we can.

I appreciate the testimony of this panel. Let me just help some of my colleagues who are absent and play a bit of a devil's advocate here. What I am hearing is that this panel would support legislation restricting physician ownership in areas to which they refer, but arguably there are some who disagree with you.

Each one of you might address one of these issues: One, one could make the charge that, as two of you are radiologists, I presume, and the other is in business with radiologists, that you all have a closed fraternity and you just do not want to let any of the new guys in.

Therefore, in the same town that you may complain that there is an unfair ownership referral arrangement, you all have so many radiologists in town and the new guy out of school with a big debt to pay cannot afford to get into the practice, if you will, and get any referrals. It is a clubby sort of arrangement among radiologists and you all have social and long-term connections. This young doctor may have to come to work for you and do his or her internship and then maybe they are let into this club. I have not heard that argument recently, but I suspect you may be asked about that, and one of you might like to deal with that.

Second, there is, of course, the question of what is wrong with all this. It is not against the law to make these referrals if it is not a Medicare patient, and I would like you to address this. It occurs to me—and I mentioned this to Dr. Todd—that if my child had to go for a CAT scan or an MRI examination, I might be far more comfortable discussing the results of that with a pediatrician who knew me and knew the kid. I would not know the radiologist who read it. I would not quite know what it meant. What is it going to mean to my family and my child? So, there may be an interface function that the primary care physician provides, and maybe you all ought to pay him something for that.

What I am suggesting is, if nobody is going to obey this law, if we are just creating a cottage industry here for lawyers and accountants to figure out how to get around this referral thing, maybe we ought to institutionalize it. We have now a resource-based relative value scale and a whole group of people who are going to decide what your index is. Maybe we should say, OK, go ahead, let us have referral fees where you and your peers decide that it is reasonable to do that, and how much should it be? Should 6 percent of this procedure be ceded to certain referring or primary care physicians? Let's put it out there, and we will put it into the resource-based relative value scale and we will argue, as we are now, over what the conversion factor should be, but you guys decide how you are going to split this up.

We could deal with that and control the costs. Is that an alternative, rather than trying to fight what seems to be human nature here? We could say, OK, let's all do it, but let's specify openly and publicly how it is being done. You deal with the ethical considerations and you deal through this resource based decision how you think this income should be split up.

That is question two. Is that reasonable?

The third issue that I would like you to discuss is the question— and I do not quite know how to deal with this. I understand that there is a city in the Midwest that is doing a study now on whether there are more negative or false images when these arrangements exist. I am not sure what the terminology is there, but there is some implication that, even though volume itself is not a measure of overutilization, it relates to the necessary service/unnecessary service issue, and, therefore, we are looking at the wrong issue. Instead, we should deal with the rates of negative images, whatever that means.

So, I am going to again play the devil's advocate in an area in which I am completely unfamiliar, and those are my three questions. Do each one of you want to take one? What about the clubbiness? Dr. Isikoff, you are the guy, in Titusville, Fla., how many radiologists are there?

Dr. Isikoff. There are eight of us.

Chairman Stark. Do you know them all?

Dr. Isikoff. They are all partners.

Chairman Stark. By first name?

Dr. Isikoff. They are all partners.

Chairman Stark. You belong to the same health club and YMCA. You do not go to country clubs, I know, because you do not get paid enough.

Dr. Isikoff. We belong to the same golf course.

Chairman Stark. So, what about the charge that a new guy coming into town, unless you like him or her, does not have a chance?

Dr. Isikoff. My group does not have an exclusive contract with the hospital. My group functions in that hospital in an identical fashion to the surgeon who functions in that hospital or anybody else. Radiologists who want to come to our hospital and get privileges, we do not have a contract that precludes that.

Chairman Stark. Let's not talk about Titusville, but let's talk about Wapakoneta, Ohio, wherever that is. Is it a fair charge? The reason you do not like this ownership referral thing is because you have an exclusive club now, and, therefore, you are worried about the competition to your collegial sort of accommodations.

Dr. Isikoff. No, I do not agree with that, although that argument is made by a lot of people. The reason I do not agree is that, if you look at Florida, and myself included, I am in joint ventures. I was put out of business once, because I refused to get into a joint venture, and subsequently, because I have a family to provide for, I joined joint ventures. I am making a lot of money in joint ventures.

Joint ventures, whether they are physician owned, referral physician owned or radiologist owned, the radiologist is still going to be the one reading the x ray images. By and large, these joint ventures are going out and hiring radiologists, and to the extent that there is overutilization in these facilities—and I can guarantee you, in my experience, there is—we are making a lot of money.

The radiologists in the State of Florida are doing very well for themselves and we have the worst joint venture State in the country. I am doing very well for myself. It is not an issue of money to me, it is an issue of ethics, it is an issue of trust, it is an issue of all the intangibles that are hard to quantify in this study.

Chairman STARK. Dr. Moorefield, what about the idea of just institutionalizing this and saying, if everybody is doing it, let's figure out a way to make sure that it is done fairly and equitably and plug it into the RBRVS and then you do it that way?

Dr. MOOREFIELD. Mr. Stark, as I understand your question, what you are asking us to do or to think about is to institutionalize a kickback. It seems to me if you pay a commission for——

Chairman STARK. Well, if you called it a fee-sharing arrangement, that is a little less pejorative.

Dr. MOOREFIELD. You are asking us to institutionalize a fee-sharing arrangement. Sharing starts with the same letter as splitting, so I think we get around to the same point.

You are asking us to institutionalize that or pay a commission for the referral. I submit that that is not only ethically abhorrent, and even the organizations that have taken a relatively soft stand on this issue would probably recognize that as wrong, but in some States, California being one of them, a payment for a referral is against the law, as was mentioned in Florida, so I would reject that out of hand.

I do not think that anybody should be rewarded for a referral, because you keep in the equation the incentive to do something that may not be medically warranted, because he is going to get paid now a known fee——

Chairman STARK. Doctor, I understand exactly what you say, but let me argue again, let me be the devil's advocate and say that fee for service medicine is the ultimate self-referral. I mean, if you carry this, a radiologist makes the decision about was that image fuzzy, should I take the second and third. Where you bill for the second and third, one could argue that you are referring to yourself and, therefore, there is some conflict of interest inherent in those decisions.

All I am suggesting is that, not in a bad sense, but if we are going to have a bunch of lawyers and accountants and people dreaming up complicated ownership schemes to get around laws on kickbacks or commissions or fee splits, I am just saying, wait a minute, if this is so pervasive in the entire practice of medicine, why not come back and put you all in control?

There must be times when doctors work together now and figure out fees yourselves. Is there anything wrong with letting you all determine fee-splitting, not us—you have got a mechanism for doing that now—and then come back and we will just argue about how much money we have got to spend next year? That might solve it, and we wouldn't have court cases and the Inspector General trying to chase people down.

Now, this may not work from the standpoint of ethics and morals. If you assume 91 percent of the doctors are in the tank, we have got one or two options. We can start prosecuting 300,000 doctors and you and I will be long gone before that has ever happened. On the other hand, we could say, OK, let's not have any more money being spent every year just on doing this, let's plug it into a fee.

You still do not like it?

Dr. MOOREFIELD. I still do not like it. Congressman, if you passed legislation which prohibited these referral practices you would not have the problem you are seeing today, where the laws allow for the butter to come out between the fingers, and to allow for these arrangements and lawyers to make a killing.

Chairman STARK. It is already against the law. It is tough to prosecute, I am told. I am not a lawyer, but they tell me intent is tough to prove. In other words, basically, to put it in late-night television vernacular, I have to get you "wired," on videotape, with the cash, referring to Mrs. Jones, and say, "Thank you, Dr. Smith. Here is a hundred bucks for sending Mrs. Jones," and the guy says, "Thank you very much." He might as well give you a receipt. Then we have you—maybe.

But, I mean, we probably have you under entrapment.

Dr. MOOREFIELD. I submit there is a way of doing it, especially through the Medicare program, and the steps are in place to do that now. We now have these UPIN numbers—Unique Physician Identification Numbers. By tying that to ownership, a simple computer program could reject for payment—you could prohibit it by the reimbursement mechanism, in other words.

Chairman STARK. I know it is Mr. Gradison's—I probably stepped on his question a little bit. A third question that I had was this issue of negative imaging and the thing you wanted to raise. Why do you not rephrase it, because I know you understand it better than I do.

It was my third question about—is there something more than just pure volume, as a way to assess this. I will then yield.

Mr. GRADISON. I thank my Chairman.

First of all—this is not a thought-through idea, and I know it—but maybe the easiest way to deal with this is not to change the ownership arrangements at all, but say that if there is any ownership involved of a facility to which a physician makes a referral, that the reimbursement rate will be—and these studies could help us tell how much—50 percent of what it would normally be, or two-thirds of what it would normally be, or it is pegged to the market price of what is charged for the same service by the nonphysician-owned ones in the same locality, or the same State, and then be done with it.

Then you do not have to turn everything upside down, but you do not permit that increment of higher price, which the Florida study suggests has happened.

Does that make any sense?

Dr. Isikoff. I think, Congressman, that is one part of the equation. There certainly are increased charges seen in many places where there a prevalence of joint ventures.

I am a physician, and I can address, from my personal experience, and some data, the fact that there is overutilization, and I will call it unnecessary utilization, going on.

Mr. Gradison. You measure this by the number of negatives?

Dr. Isikoff. Yes. There is a number——

Mr. Gradison. I mean, is it measurable?

Dr. Isikoff. There are a number of ways. To quantify it, you would look and see how many studies were negative. In the case of my colleague here, before and after a joint venture.

I can look at a request that is submitted to me, about a particular patient, and looking at the history on that patient, make a decision whether I think that study is indicated or not. That is my specialty. That is what I am supposed to do.

And I can assure you that in my experience, and in the experience of almost every radiologist that I have ever talked to, there is tremendous overutilization, unnecessary utilization, occurring in joint ventures. These things are incredibly profitable, and doctors are overutilizing them.

Sure, if you get a good study of the negative rate in a particular facility, you would see that there were more negative studies in facilities that are overutilizing, but that is somewhat hard to do.

Mr. Carl. Mr. Gradison.

Mr. Gradison. Yes, Mr. Carl.

Mr. Carl. On behalf of Health Images, I would like to comment that we do have that data. In a situation—it was a Florida center, incidentally—where we bought out all the physician investors. So we can compare negative rates before and after the buyout, and I have people here today that can share that data with you.

Mr. Gradison. I would be very happy—I am sure my colleagues on the two subcommittees would, as well—if you could perhaps share that with us, after the hearing, in writing.

[The following was subsequently received:]

Health Images, Inc.

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p. 76

THE STUDY

Comparison of Negative/Positive MRI scans in Health Images, Inc. wholly-owned MRI centers with a Health Images limited partnership with self-referring physicians owners

Objective

To determine to what extent, if any, financial incentives affect physician referrals as evidenced by an increased rate of negative pathology findings. If the negative rate (no pathology found and a direct indicator of the medical necessity of a MRI scan) is higher at a Health Images physician joint-ventured center than that found at Health Images MRI centers without physician partners, then a correlation can be observed between financial incentives, physician scan order rates, and the medical appropriateness of scans ordered.

Assumption

Diagnostic exams, by definition, are exploratory and will never exhibit a 100% positive rate. It is generally accepted that a negative rate between 10% to 30% is "normal" for routine diagnostic imaging services.

Data Studied

Study A: Health Images, Inc. analyzed patient MRI scans conducted at one of our joint ventured MRI centers for two (2) separate periods: (1) August 1986 through July 1987; (2) January 1988 through December 1988. Health Images sold 33 limited partnership units to 34 physicians and retained the remaining 54 units for its own account.

Study B: In contrast, we studied the overall negative/positive scan rate on random series of approximately 3000 MRI scans (C-spine, knee, pelvic and head) performed at all of Health Images MRI centers(20+) that were wholly-owned (no physician limited partners) during two separate periods: (1) 1990 and (2) 1991.

Study A:

Period (1): August 1986 through July 1987(random selection by month)

Total scans evaluated	1056	100%
Negative findings	624	41%
Positive findings	432	59%
Total scans referred by limited partner physicians	749	71%
Total non-limited partner scans	306	29%

Period (2): January 1988 through December 1988(random selection by month)

Total scans evaluated	960	100%
Negative findings	449	47%
Positive findings	511	53%
Total scans referred by limited partner physicians	634	66%
Total Non-limited partner scans	326	34%

Study A Conclusion: The average negative scan rate for the two periods studied was 44%

Study B:

Period (1): 1990 (2924 scans from 20 centers)

Total scans evaluated	2924	100%
Total Negative findings	815	27.8%
Total Positive findings	2109	72.2%

Period (2): 1991 (3480 scans from 21 centers)

Total scans evaluated	3480	100%
Total Negative findings	1078	31%
Total Positive findings	2402	69%

Study B Conclusion: The average negative scan rate for the two periods studied was 29.4%

Overall Conclusion

Financial incentives given to physicians through limited partnership interests in MRI centers proved to generate an average negative scan rate of 44%. Without financial incentives (no limited partnerships sold to referring physicians) the average negative scan rate was 29.4% or 15% lower.

The 15% increase in the average number of negative scans found at our facility with self-referring physicians compares unfavorably with data collected at over 20 of our MRI centers where no limited partnerships were sold.

It is reasonable to assume that the 15% higher negative scan rate is directly attributable to the financial incentives provided to referring physicians through their limited partnership unit(s). The 44% negative rate at the limited partnership MRI center is significantly above the expected "normal" negative rate of 10-30%, indicating a lack of medical necessity.

Mr. GRADISON. I do have a question for you, Mr. Carl. My understanding is your company operates in quite a few different States, and I wonder if you could give us some insight into how Florida compares, and whether this is a general experience, and is Florida just further along in the ultimate development of these things?

How does this look to a multi-State operation like yours?

Mr. CARL. OK. I think I can address that.

The Florida experience is by no means unique. There is rampant self-referral in our key Atlanta markets, where I think we have 33 or so imaging centers in Atlanta. To put that in perspective, I think there are 34 in the entire United Kingdom—57 million people versus 2.4 people in metropolitan Atlanta.

We operate centers in Pennsylvania, including two in Philadelphia. That area is heavily populated with physician-owned imaging centers.

We find them in all of our markets—New Jersey, South Carolina, and I might add, especially Texas comes to mind as being an area where there seems to be a lot of this. On the other hand, I would say, in the State of Maryland, where we have one center, I see relatively less of it.

Mr. GRADISON. Let me pursue that a little bit.

I do not know, from what the previous panel said, what is going to develop in Florida. But it is possible, at least, that they might attempt to enact a State law that prohibits self-referral for diagnostic imaging centers.

Would that solve the problem as you see it? Or is there more to it than this? Are there some unintended consequences that might arise?

Mr. CARL. I think if such a law were passed, it would help the situation greatly, and I would support such a law, both at a State level and at a national level.

Mr. GRADISON. Thank you.

Dr. MOOREFIELD. Mr. Gradison.

Mr. GRADISON. Of course, Doctor. I did not mean to cut you off. Please. On any of these points that I have raised. Of course.

Dr. MOOREFIELD. You emphasized overutilization, and I would like to emphasize one other part of this, in relation to the question you asked about adjusting payments from a self-referred facility versus the other.

The facility that controls the physician marketplace is still going to prevail, and you will still have an anticompetitive situation. In other words, if a community has two facilities, and one of them has 100 of the 120 physicians in the community as investors in that facility, even at a lower payment, unless you drove the payment so low as to force them out of business, that facility would prevail, and the other one would still be in a disadvantageous position.

Mr. GRADISON. I hope it is clear. I was not really trying to suggest a punitive payment system. What I had in mind, conceptually—and I am not sure this could be implemented—would be what I would call a "most-favored-nation arrangement," where you would say, "Look, we are not going to pay anybody any more than we are paying the group in town that gives us the best deal and has a record of good quality," and that would set the price for the only programs that we are responsible for.

I understand your point, that they might make it up on other business—non-Medicare business—and, further, that there might be enough profit in it, yet, to still justify sending the patients to that center.

Dr. MOOREFIELD. The Medicare fee schedule to be promulgated in January should level the playing field as far as payments are concerned. They should be the same, in the same area, for both facilities. So, as far as the Federal programs are concerned, that should be fairly well set.

But, I still would like to emphasize, that when you have purchased the marketplace, you have basically an anticompetitive situation, despite all the statements made that these are procompetitive, they are, in fact, monopolistic, anticompetitive entities.

Mr. GRADISON. We do not have much information about the rural areas in Florida. Apparently there are not any such centers.

I always worry about unintended consequences. Maybe I worry too much about them, and I may have been taken in by what I am going to say to you, but let me tell you what I was once told.

I was told of a medium sized community, in which the physicians were extremely unhappy with the hospital that was doing the imaging work. They felt that the person who ran the department was not fully qualified. These physicians alleged that the hospital administrator would not do anything about it, and that in the interest of quality they put up a center right across the street from the hospital, in order to make sure that their patients were getting the kind of quality that they really would have liked to have had from the hospital.

Now, this kind of an approach would say, "No." I mean, basically, I would assume that it benefits one group—maybe a group that should be benefited—but one kind of an arrangement versus another.

Dr. ISIKOFF. I would like to address that. In fact, in my community, the rationale for virtually all the joint ventures that went up—and there are five or six or seven of them—was that the radiologists were no good. And virtually every community—if you are in a community where you have to make a rationale, and usually that is a smaller community where you just cannot put one up, and where there is one hospital—that has always been the case.

If you looked at it that way, there is not a good radiologist in this country. All of us are bad radiologists. And what I would say is that when you look at these joint ventures, at least many of them, we are talking about a venture that very frequently ends up being of less quality than the facility that they ran out of business, as in my case, or that they are competing with across the street.

Most joint ventures end up doing what I described, and what Mr. Carl described. They go and get the cheapest radiologist they can find. They do not upgrade their equipment. They have a captive audience. They do not need to continue to maintain quality. Even if they start out with quality, they do not maintain it, and the bottom line is that at some point in time, that facility is not providing the quality of service that a truly independent facility would and could provide.

Mr. GRADISON. I understand that possibility, and I have no doubt that it frequently exists. I also recognize that that is not the only possible outcome.

The imaging center in my home town, that I have visited and stayed in touch with, which was put together by a number of neurologists in our city, hired, as a group, the same pathologists that do the readings for the university hospital, in the very interest of being able to say the quality is the same—we have the same people.

They are now doing an internal study, to try to make a comparison of the negatives, and this question of overutilization of their own center, versus the university hospital. I do not know what that is going to show. But it does suggest to me that it is possible to get to some of this data, I do not know. Maybe I have more confidence in the ability of people to find a way around our rules than is justified.

The phrase that always pops into my mind when we are talking about something like this is that for every regulation there is a way around it. I guess, not knowing what that might be, and not knowing the field, and while I agree with the thrust of what you are saying, I just wonder whether it will work.

Dr. ISIKOFF. I do not know. I hope it will——

Mr. GRADISON. I know you do.

Dr. ISIKOFF [continuing]. Because I can assure you that the system that I am working with in Florida is untenable. The system is abusing patients. It is abusing those ethical doctors who are not in favor of it.

I have physician friends who have been forced to join joint ventures that he did not want to join by being told that if he did not join it, he would never see another referral.

We are out of control in the State of Florida. There are other States that are approaching that, and I do not know what the answer is, except that we need something done.

Mr. GRADISON. Well, I guess one final thought—and this is my caution, again, coming to the surface. What you said does not necessarily convey to me that we have to have a national solution. Because Florida thinks it has a problem, the legislature had a study made, they are going to make some recommendations. If they want to deal with this, they can do it. They do not have to limit themselves, as this committee would have to do, to Medicare. They can do it across the board and have a whole lot more impact if that is the way they want to go.

Dr. ISIKOFF. We are going to do that. The State of Florida will have a bill that is going to be introduced in this legislative session. The exact specifics of the bill I am not sure about yet, but we intend to do it.

But, what we are going to do by doing that, if we get the bill through, is export this to the States that do not have laws, and that problem—you will be addressing that problem at some point in time. It may not be this year, but at some point in time, if we outlaw it, all of the entrepreneurs in Florida will be in your State, and your State and your State, doing exactly the same thing.

There is too much money to be made in this not to.

Mr. **Gradison**. I do not think there is room for many more in my town.

Excuse me, Doctor?

Dr. **Moorefield**. I would like to comment on that, too.

We would have to wait for 50 legislatures to take care of the problem, and of necessity, that would take some bit of time. In the meantime, the Federal programs are not protected from this overutilization, and money that they pay, thinking they are paying part B payments to physicians who are actually providing the services, or even, in some cases, there are probably some part A payments being transferred, going to people who are being paid for providing none of the services for which you intended this money to go.

So, I think that the Federal program should not wait for the States to march 50 times, through the legislatures.

Mr. **Gradison**. Thank you. Thank you all, and thank you, Mr. Chairman, for your patience.

Chairman **Stark**. I want to thank the panel very much for their participation and their help to the committee. Your staff and our staff have worked together, and you have been very helpful in providing us information. We appreciate it very much.

Our next witnesses will comprise a panel. We will hear from Dr. Donna Miller, chief executive officer of the Memphis Business Group on Health; Dr. James Schwade, who is chairman of the department of radiation oncology at the University of Miami in Miami, Fla.; Dr. Marilyn Moffat, who is the president of the American Physical Therapy Association; Lawrence Shauf, who is the chairman of the Independent Private Practitioners of Physical Therapy; and Dr. Mark Cooper, who is director of research for the Consumer Federation of America.

If you would all like to go ahead in the order in which you were called, and if you could summarize or expand on your prepared testimony in approximately 5 minutes the Chair would appreciate that. Just go right on through.

If there is a vote, we will either try to take turns getting over to vote, or recess briefly as we proceed.

Dr. Miller, would you like to start out?

Ms. **Miller**. Yes, sir.

STATEMENT OF DONNA MILLER, PH.D., CHIEF EXECUTIVE OFFICER, MEMPHIS BUSINESS GROUP ON HEALTH

Ms. **Miller**. I am Donna Miller, the chief executive officer of the Memphis Business Group on Health. We are a not-for-profit organization of 32 employers, and we work to help members contain their health care costs while still ensuring access to high quality care.

I was invited here today to testify about a situation that currently is going on in Memphis in regard to lithotripsy services. Until May of 1991, virtually all patients in Memphis needing lithotripsy were able to receive the services via a machine that was jointly owned by six hospitals and some urologists in Memphis. In May, a mobile unit was brought to Memphis. That machine is owned by virtually every urologist in Memphis, as well as by Lithotripters, Inc., a North Carolina company. Memphis hospitals were informed by the urologists that the group would no longer use their machine. The charge for the hospital machine had ranged between $3,300 and $3,600 per procedure. That increased to $7,100 per procedure with the physician-owned machine.

In addition to the $7,100, there is a $2,000 physician's fee for every procedure.

We have had some other proposals brought to Memphis that would dramatically decrease the charge, but without the urologists willing to perform the procedure, we have not been able to pursue those options.

If you look at this from the perspective of out-of-pocket cost per patient, under the old machine in an 80/20 plan, the patient would pay $552 out of pocket. Under the new physician-owned machine, in an 80/20 plan, the patient would pay $1,420, which is a greater than 2½ times increase in out-of-pocket for the patient.

In addition, because of various managed care contracts, and that not being available as a PPO machine—preferred provider—for some patients, the out-of-pocket would increase to $2,130.

The refusal of the physicians to use existing units is based on the argument that the machine is more modern, does not require hospitalization or anesthesia. We are not arguing that point. Our concerns are over the amount of the charge, restriction of options, and referrals made by the same physicians owning the machine.

Two arguments have been used to justify the increased costs.

Number one, the machine is over $2 million, and costs must be passed to the consumers. That argument simply does not make sense when you examine the financial facts. The projected number of treatments in the Memphis area in 1 year is between 1,000 and 1,200 treatments on the lithotripsy. If you multiply that by $7,100, that results in between $7 and $8.5 million per year for use of the one machine. That does not include the $2 to $2.4 million for the urologists' fees.

Even with overhead costs associated with operating this mobile unit, a tremendous opportunity for huge profits exists with this venture.

The second argument was that the machine does not require hospitalization or anesthesia and is saving money in that respect. First, that is not entirely a valid argument, as many of these patients still have to be hospitalized for pain control or for complications.

Also, when you remove costs in one area, it does not justify adding it to another area.

In summary, our concerns are not just the cost. It really is a much larger issue, and that is allowing patients access to care, without the potential conflicts that exist in situations such as the one in Memphis.

The business community is very concerned about these types of situations, and hope to get this addressed at a broader level.

Thank you.

[The prepared statement follows:]

STATEMENT OF DONNA MILLER, PH.D., CHIEF EXECUTIVE OFFICER, MEMPHIS BUSINESS GROUP ON HEALTH

Mr. Chairman and Members of the Committee:

I am Donna Miller, Chief Executive Officer of the Memphis Business Group on Health (MBGH). MBGH is a not-for-profit organization of 32 employers with the primary function of assisting the member companies in their cost containment efforts while still ensuring access to high quality health care for their employees.

I was invited here today to testify on a situation currently occurring in Memphis with regard to lithotripsy services. Simply put, lithotripsy is the breaking up of kidney stones by the use of shockwaves. To more clearly define the role of MBGH in this controversy, a brief historical background is provided.

In addition to general data and benefit plan analysis services, MBGH performs utilization management and negotiates preferred provider arrangements (PPO's) for members. The hospital PPO is with Baptist Health Services of Memphis. Participating employers and employees receive a 20% discount off all hospital services. Employees opting to obtain care from a PPO facility also receive a higher copayment. For example, the patient may be covered for 80% of charges for care received at a PPO facility and only 70% if they opt to go outside of the network.

This last feature of the PPO arrangement is very important as it could help to explain increased interest by physicians in ownership of facilities and equipment. There is a maximum fee schedule for care provided by PPO physicians. Those physicians, by contract, agree to accept the maximum fee schedule and cannot balance bill the patient for amounts above the schedule. Physician payment schedules almost always include some type of "usual and customary" (U&C) statements that limit payment to fees within an acceptable range for that community. Under some U&C arrangements, physicians can bill the patient if their fee is above U&C. That normally is not true under managed care contracts, as they contain requirements that the physician not balance bill the patient. **There traditionally have not been U&C type restrictions on facilities or equipment. Payment on these entities is based on the billed charges and usually covers the plan's copayment level to 100% of the charge. Additionally, if charges are not paid by the plan, patients are responsible for the difference.** This lack of control of maximum charges may be a leading reason for increased interest in physician ownership.

Until May 1991, patients requiring lithotripsy had the procedure via a machine that was jointly owned by six Memphis hospitals and a group of urologists. That machine is an older model and requires anesthesia and hospitalization. According to a representative of Baptist Health Services, the fee for use of that machine ranged from $3,300 to $3,600. There was an additional fee of $2,000 for the urologist performing the service.

In May, a mobile lithotripsy unit was brought to Memphis. That machine is owned by virtually every urologist in the area as well as by Lithotripters, Inc., a North Carolina firm. Memphis hospitals were informed by the urologists that the group would no longer use the machine jointly owned by the hospitals. The charge for the procedure increased from the range between $3,300 and $3,600 to a fee of $7,100, along with the $2,000 fee for the urologist.

MBGH recently received a proposal from a California firm offering to bring a similar machine to Memphis and provide services for $1,100 per treatment. Needless to say, that fee is preferable to $7,100. However, it is my understanding that the urologists have signed an agreement not to perform procedures on any machine other than the one owned by the group. Area hospitals expressed willingness to purchase the updated machine, but without urologists to perform the procedure, they have not pursued that option.

To determine the significance of the financial impact on patients, a breakdown of out-of-pocket costs for the hospital owned machine and the physician owned machine is presented:

Hospital Owned
PPO
Average charge = $3,450
- 20% PPO discount = $690
New charge = $2,760
80% of $2,760 = $2,208 (plan pays)
20% of $2,760= $552 (patient pays)

NON-PPO
Average charge = $3,450
No discount available
70% of $3,450 = $2,415 (plan pays)
30% of $3,450 = $1,035 (patient pays)

Physician Owned
Is a NON-PPO machine
Charge = $7,100
No discount
70% of $7,100 =
$4,970 (plan pays)
30% of $7,100 =
$2,130 (patient pays)

The refusal of the physicians to use the existing lithotripter is based on the argument that the newer machine is more modern and does not require hospitalization or anesthesia. That is probably a valid argument, even though studies suggest that patients treated on the new machines are more likely to require retreatment because stones are not adequately broken up. That point is not being argued. Our concerns are over the amount of the charge, lack of a PPO option for patients, and referrals made by the same physicians owning the machine.

The following arguments are used by the urologists to justify the increased charge:

1. **The machine is two (2) million dollars and costs must be passed to the consumers.** That argument simply does not make sense when you examine the financial facts. The projected number of lithotripsy treatments for the Memphis area population is between 1,000 and 1,200 cases per year. Those numbers multiplied by $7,100 result in between seven (7) and eight and one-half (8.5) million dollars generated a year, just for the machine. That does not include the 2 to 2.4 million dollars for physician fees. Even with overhead costs associated with operating the machine, a tremendous opportunity for huge profits exists with this venture.

2. **The machine does not require hospitalization or anesthesia and is saving money in that respect.** First, this is not an entirely valid argument as a fairly large number of these patients must be hospitalized for pain control and/or complications to the procedure, regardless of the machine used. Second, even if true, removal of costs in one area does not justify increasing costs in another area. The comparison must be made machine to machine, independent of other factors. One of the most compelling justifications for public financial support of health care technology research and development is for it to result in simpler, less intrusive, and more effective health care. To justify additional costs when the technology produces those outcomes, again, simply does not make sense as the public pays twice for that development.

In summary most of the citizens of Memphis do not have access to lithotripsy services without using the machine owned by the urologists. Though charges are an issue, lack of access and physician ownership/referral is the greater issue. In six years at the business group, I cannot remember an issue that has stirred this much controversy. The numerous newspaper accounts have resulted in telephone calls from health care professionals, employers and patients. Some of the patients were not even associated with MBGH member companies. They were disturbed as they were not informed by their physicians of the part ownership arrangement or anything regarding costs for the procedure.

Concerns of the business group do not end with lithotripsy. Other potential conflict of interest situations surrounding "self-referral" are evident in Memphis, as well as nationally. Last week a bill for an outpatient knee surgery from a physician owned surgery center was $3,481. When matched for identical services and procedure codes, the same surgery from the PPO hospital would have been $896 minus the 20% discount, with a resulting charge of $717. The physician owned charges were almost five times greater than the hospital charges for exactly the same procedure. In a society where health care costs are already unmanageable, any potential for conflict of interest is intolerable. **At least, patients have the right to information regarding their physician's ownership of facilities and equipment to which they are sent for services or care. More importantly, potential conflict of interest in these situations should be eliminated by removing the potential of that conflict.**

Thank you for the opportunity to be here today. The business group stands ready to work with you as these efforts proceed.

Chairman Stark. Thank you.

Dr. Schwade.

STATEMENT OF JAMES G. SCHWADE, M.D., CHAIRMAN, DEPARTMENT OF RADIATION ONCOLOGY, UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

Dr. Schwade. Thank you, Mr. Chairman.

Mr. Chairman, my name is James G. Schwade, M.D. I am the chairman of the department of radiation oncology at the University of Miami School of Medicine and professor in that department. I am certified by the American Board of Radiology, and have been practicing, teaching, and consulting in radiation oncology for approximately 18 years.

Although much of my career has been in academic institutions, and the National Cancer Institute in Bethesda, Md., almost 6 years of my clinical experience was in a community setting as chief of the department of radiation oncology at Baptist Hospital of Miami.

I am familiar with referring-physician investments in radiation therapy centers and other health care entities, having seen them proliferate in recent years, and in particular, in Florida.

I am here to urge you, in the strongest terms, to pass legislation which will prohibit the ownership of radiation therapy centers by physicians who refer patients to those centers.

First of all, let me state very forthrightly that I am a strong advocate of entrepreneurealism and the investment of private capital in medicine, and the creation of medical facilities. Further, I believe very strongly that competition breeds quality.

However, the ownership of radiation therapy facilities by referring physicians eliminates competition and adversely impacts quality, cost and accessibility.

Competition exists when two individuals or entities vie for a customer or client by providing either a higher quality, lower cost, or otherwise more efficient service. It is not competition when a physician directs a patient, who has a life-threatening illness, to attend a facility from which that doctor derives financial gain other than from his own treatment of the patient.

Regardless of the quality of service that another facility can offer, there is no way that it can effectively compete, unless that other facility also provides some financial remuneration to the referring physician. This is not competition. No matter how it is structured, conceived or concealed, it is what is—a kickback.

It was not too many years ago that organized medicine, and the commonly accepted standards of medical ethics, condemned such a practice.

This practice is particularly abhorrent in radiation therapy for several reasons. First of all, it preys on extraordinarily dependent and vulnerable patients facing the catastrophe of a life-threatening illness. Those patients have put their trust in an individual—their physician—and are relying on that physician to make a judgment about their care, which they themselves are unable or unqualified to make.

They are at the mercy of the referring physician to decide who should deliver that care. When that referring physician makes a choice, or even is in a position to make a choice that is not totally based on the needs of the patient, but rather can be influenced to the smallest degree by the physician's own financial interest, that trust is violated.

Unlike conflicts of interest in other professions where only money may be at stake, here we are dealing with human lives. Referring-physician ownership of radiation therapy centers simply should not be permitted. Competition should be dictated by a facility that delivers better service for the patient, not by remuneration for the referring physician.

The independence of referring physicians, and the public's confidence that the decisions which they make are solely in the patient's interest is paramount, and cannot and should not be compromised. There can be no doubt that the position of the doctor as advocate for the patient is sacrificed in these self-referral arrangements.

Moreover, quality is compromised, although in a more subtle way. When a group of referring physicians control a facility in which another specialty is practiced, tremendous potential for overutilization takes place. There are individuals or groups who falsely claim that in radiation therapy there is no such potential for overuse.

For example, some have purported that there is little prospect for abuse in treating patients with radiation therapy because "they all have cancer." This is patently false. Nearly all patients receiving radiation therapy have cancer, but not all cancer patients should or do receive radiation therapy.

Experience has shown that consistently 15 to 20 percent of patients evaluated in a radiation oncology department do not receive radiation treatment. The Patterns of Care Study conducted by the American College of Radiology indicated that only 60 percent of all cancer patients ultimately are treated with radiation therapy.

Thus, there is a tremendous potential for abuse through overutilization, and the resulting decrease in quality and increase in cost. If all of this sounds too hypothetical, let me assure you that such arrangements presently exist. I know of numerous examples.

In closing, I would urge you to take strong steps to prevent physician ownership of facilities to which they can influence patient referral. The potential harm to patients, as well as the significant increase in our escalating health care costs, which must ultimately be borne by the public, outweigh any benefits of these types of arrangements.

If you allow them to be safe harbors, they will be harbors into which some ultimately will sail to the detriment of all.

Thank you.

[Supplemental material follows:]

SUPPLEMENTAL MATERIAL TO
TESTIMONY OF 10/17/91 BEFORE
THE HEALTH CARE SUBCOMMITTEE OF
THE COMMITTEE ON WAYS AND MEANS OF
THE U.S. HOUSE OF REPRESENTATIVES
PRESENTED BY JAMES G. SCHWADE, M.D.

October 29, 1991

Physician owned joint ventures lead to overcapacity, overuse, and increased costs to the public. There is now increasing evidence that this is the case. While it is difficult to find specific instances of abuse of individual patients, there is increasing evidence of overuse by specific facilities in a number of locations:

In Atlanta, Georgia, the practice of Dr. Dale McCord and his associates, averaging 45 patients under treatment each day, in a short time dropped to 18 patients per day, while the radiation therapy unit constructed nearby by Radiation Care, Inc. grew to 40 patients per day in the same time. Thus, in a short time 58 patients on the average were treated in this locale, an increase of 29%. At the meeting of the Florida Health Care Cost Containment Board on October 24, 1991, Doctor Schweibold from Radiation Care, Inc.'s Atlanta practice admitted that 90% of his patients were referred by physician/investors. At the time it opened he said it was 100%.

This pattern has been repeated in Nashville, Tennessee, where Dr. Steve Stroup's practice was similarly affected, Charlotte, North Carolina, where Dr. Tim Cloniger and his associates also had their practice devastated, and in the Miami, Florida, area.

In Miami there have been numerous instances where the creation of self-referral based free-standing radiation therapy centers have led to overcapacity. At Baptist Hospital of Miami and South Miami Hospital, a group of over 100 physician investors created a radiation therapy center, Kendall Therapy Center, located within several miles of both hospitals. This was done at a time when Baptist Hospital had a state-of-the-art facility with a national reputation, and South Miami Hospital had announced plans to build a facility. Therefore, capacity and quality were not issues. In fact, the referring-doctor investors hired the same doctors which were eventually selected to run the facility at South Miami Hospital. These doctors, however, were encouraged to treat patients at the doctor-owned facility which they also worked. Thus, in an area where 80 patients per day were under treatment in 1987, a total of 110 patients per day are now under treatment (55 at Baptist, 20 at South Miami and 35 at Kendall Therapy Center). This exceeds the projected number based on population growth and has resulted in three centers with seven treatment machines (linear accelerators) in an area requiring only three to four machines. It is the public that must bear the cost of this overcapacity.

At Hollywood Memorial Hospital, in Hollywood, Florida, a private developer organized a large group of the hospital's referring physicians to build a free-standing radiotherapy unit within several blocks of the hospital. Eventually, the hospital purchased this unit. Thus, today there is twice as much radiation therapy equipment as is needed in the area. This developer repeated this pattern in several Florida cities.

Other examples of these behaviors in the Miami area include the sale to referring physicians of a free-standing practice owned by the physicians who delivered the treatment near Parkway Hospital in Miami. These doctors were encouraged to sell their practice to the referring physicians in order to remain in business.

Another example occurred at Mercy Hospital of Miami where the referring medical oncologists urged the hospital to replace the practicing radiation oncologists and give the hospital's contract for radiotherapy services to the medical oncologist. They then subcontracted through an elaborate partnership structure with a new radiation oncologist.

In all these instances the result has been the same: overcapacity, with the existing practices frequently owned by community hospitals being affected severely, but not enough to be put out of business, and the community essentially supporting both facilities at less then optimal levels with an increased total number of patients under treatment. It is logical to assume that some of this increased number may have had marginal or no definite indications for radiation therapy.

Let me reiterate that there is tremendous potential for abuse in radiation therapy. According to the Patterns of Care Study, only 60% of all cancer patients receive radiation therapy. The indications for treatment are not "cut and dried." Treating cancer takes a lot of judgement about the most appropriate treatment for each individual patient. No two are alike, even with similar types of tumors at similar stages.

While the radiation oncologist (radiotherapist), the physician who actually prescribes and delivers the treatment, makes the final decision, the primary care physician (medical oncologist, surgeon, urologist, etc.) who cares for the patient on an ongoing basis, has much discretion in who is sent to radiation therapy. Patients with marginal indications can be referred. Either pressure from these referring doctors or financial incentives to the treating radiation oncologist, or both, can cause overuse.

While the fee-for-service radiation oncologist might, if his ethics (or lack thereof) so incline him, also overtreat or overuse irradiation, there is a natural system of checks and balances which exists when his referring doctors do not financially gain by the patient receiving radiation therapy. They will not refer to a doctor who overuses or overtreats. If demand for a new center is great enough because of poor quality, then a new center should be able to compete without a self-referral joint venture structure.

At the time of the hearing on October 24, 1991, the representatives of Radiation Care distorted this arrangement. They claimed that the radiation oncologist is the "gatekeeper". As indicated in my description above, that is only part of the picture. Mr. Mills either misconstrued this relationship or does not understand it, being a paid lobbyist as opposed to a practicing oncologist.

The doctor from Radiation Care misquoted the American College of Radiology Patterns of Care Study. In criticism of my testimony, he stated that his proportion of patients evaluated for treatment but not receiving treatment ("seen but not treated", or "SBNT") was 13.1-20%, which he claimed was consistent with the Patterns of Care Study.

A careful reading of my testimony will reveal that I stated that the 15-20% proportion of SBNT was from general experience. In fact, the Patterns of Care Study has no data that I'm aware of on SBNT patients. Thus, this doctor was clearly not familiar with the subject matter and in particular the Patterns of Care Study.

In fact, according to Dr. Gerald Hanks of the Fox-Chase Cancer Center in Philadelphia, the current proportion of SBNT patients is currently 20-25% nationally. This is an increase, thought to result from the increasing tendency of patients to seek second opinions and explore alternative sites and modalities of cancer treatment.

Additional evidence that these types of self-referral centers lead to overuse is contained in the material which I am including (figures A and B, and enclosures C and D, which was provided to me by Dr. Jonathan Sunshine, Chief of Research for the American College of Radiology. The data is derived from the 1989 "BMAD", of Medicare Part B payments. These data examine the extent of use in treatments per 1000 medicare enrollees as well as in Relative Value Scale (RVS) units. The former measures the quantity of procedures, and the latter the intensity.

Free-standing and hospital based centers in Florida are compared with those nationally and with each other. As noted in my testimony, in the Florida Health Care Cost Containment Board Study, only 23 of the 31 free-standing centers in Florida responded. Of those 23, 10 are believed to be owned by the practicing doctors and aren't self-referral joint ventures. The other 13 represent 57% of the respondents. The proportion of free-standing centers nationwide that are self-referral joint ventures is 7% according to the American Colleges of Radiology's most recent data, which is for 1989. Thus a higher percentage of Florida's free-standing facilities are owned by referring doctors.

The data clearly show that while use in Florida is higher in both free-standing and hospital based facilities, in the latter it is only 2% higher in terms of RVS units, and 12% higher in terms of treatments per 1000 medicare enrollees. This is essentially within the statistical mean. In the free-standing units, use in both measurements is essentially 50% above the national average.

The higher proportion of self-referral investor owned free-standing centers in Florida may account for this discrepancy.

In conclusion, while the Florida Health Care Cost Containment Board Study did not clearly demonstrate overuse or abuse of radiation therapy, this was because of small sample size and lack of statistical certainty, not because the data determined that there was not overuse. In fact, the study trend suggested overuse in radiation therapy, as well. Data derived by the ACR from Medicare Part B payments do indicate greater utilization of radiation therapy in Florida, and significantly greater use in free-standing centers, which in Florida are owned by referring doctors in 57% of instances, as opposed to 7% nationally. Coupled with increasing anecdotal evidence of cases where self-referral joint ventures result in overuse, overcapacity, and lack of true competition, I believe that strong legislation must be created to ban referring physician ownership of joint ventures where self-referral is possible, regardless of structure, in radiation therapy centers.

Thank you very much for the opportunity to present this information to the Subcommittee. I am available to again do so in the future if this would be of value to the Subcommittee.

JAMES G. SCHWADE, M.D.
Professor and Chairman,
Department of Radiation Oncology
and
Associate Director for Clinical Research Programs
Sylvester Comprehensive Cancer Center
University of Miami School of Medicine
Miami, Florida

Fig. A.

RADIATION THERAPY PROCEDURES PER 1,000 MEDICARE ENROLLEES

	Centers & Offices	Hospital In-patient & Outpatient	Total, All Places
FLORIDA	139	186	325
U.S. AVERAGE	92	183	274
FLORIDA EXCESS OVER U.S. AVERAGE	52%	2%	18%

Fig. B.

RELATIVE VALUE UNITS FOR RADIATION THERAPY PROCEDURES PER MEDICARE ENROLLEE

	Centers & Offices	Hospital In-patient & Outpatient	Total, All Places
FLORIDA	1.16	0.76	1.93
U.S. AVERAGE	0.79	0.68	1.47
FIORIDA EXCESS OVER U.S. AVERAGE	47%	12%	31%

Enclosure C.

NUMBER OF RADIATION ONCOLOGY PROCEDURES
From Medicare (1989 BMAD)
15:52 Tuesday, October 22, 1991
ALL PLACES OF SERVICE

STATE	# of Procedures	# of Proc per 1000 Enrollees
Missouri	455742	609.58
Alabama	255262	460.87
California	1372717	442.51
Pennsylvania	718618	385.80
Georgia	247383	357.03
Florida	722052	325.04
Washington	182911	316.79
North Dakota	29110	306.64
Montana	33835	302.96
Louisiana	144733	289.56
Kentucky	146802	287.92
Nevada	34608	277.53
Tennessee	177343	269.34
Arizona	123424	266.46
Oklahoma	114083	265.67
New Jersey	273027	261.55
Indiana	185547	255.63
South Carolina	105889	254.28
Illinois	366409	250.54
New Hampshire	31122	241.72
Connecticut	106826	240.21
Wisconsin	156485	228.11
Ohio	329526	224.36
North Carolina	187285	222.57
Utah	32880	222.30
Idaho	27120	217.63
New Mexico	35389	213.40
Delaware	17673	212.65
West Virginia	62391	211.13
Arkansas	76373	204.31
Nebraska	46086	201.72
Wyoming	9497	195.88
Oregon	76450	191.39
Vermont	13251	186.91
Michigan	218365	185.63
Maryland	90660	179.89
New York	423618	177.72
Colorado	58172	174.99
Mississippi	61227	174.73
Virginia	116418	172.43
Texas	291536	169.45
Maine	29442	168.07
South Dakota	17164	162.65
Alaska	3269	150.88
Puerto Rico/Virgin Islands	39069	138.48
Minnesota	77275	137.17
Kansas	44046	126.16
Iowa	51620	116.77
Hawaii	12729	109.77
U.S. TOTAL	8432459	274.30

NUMBER OF RADIATION ONCOLOGY PROCEDURES

From Medicare (1989 BMAD)
15:52 Tuesday, October 22, 1991
OFFICE & CENTERS ONLY

STATE	# of Procedures	# of Proc per 1000 Enrollees
Nevada	28111	225.43
California	687558	221.64
Arizona	84769	183.01
Washington	102142	176.90
Missouri	124742	166.85
Arkansas	59390	158.88
Georgia	109798	158.46
Louisiana	73289	146.62
Florida	308952	139.08
Pennsylvania	245771	131.94
South Dakota	13771	130.50
Kentucky	54748	107.37
North Dakota	10046	105.82
Montana	10308	92.29
New York	204232	85.68
Alabama	43150	77.90
Utah	10528	71.18
Puerto Rico/Virgin Islands	19906	70.55
Illinois	100083	68.43
West Virginia	19484	65.93
North Carolina	52136	61.95
Maryland	31102	61.71
Oklahoma	25453	59.27
Iowa	25846	58.47
Ohio	83981	57.17
South Carolina	21321	51.20
Indiana	31941	44.00
Nebraska	9917	43.40
Wisconsin	26682	38.89
Minnesota	20949	37.18
New Jersey	38638	37.01
Oregon	13919	34.84
Mississippi	12113	34.57
Tennessee	19302	29.31
Texas	41852	24.32
New Mexico	3646	21.98
Michigan	22658	19.26
Virginia	12717	18.83
Idaho	2268	18.20
Colorado	4971	14.95
Connecticut	4491	10.09
Kansas	2979	8.53
Alaska	59	2.72
Delaware	215	2.58
Hawaii	204	1.75
New Hampshire	23	0.17
Maine	23	0.13
U.S. Total	2820184	91.74

NUMBER OF RADIATION ONCOLOGY PROCEDURES

From Medicare (1989 BMAD)
15:52 Tuesday, October 22, 1991
HOSPITAL INPATIENT & OUTPATIENT ONLY

STATE	# of Procedures	# of Proc per 1000 Enrollees
Missouri	331000	442.73
Alabama	212112	382.96
Pennsylvania	472847	253.85
New Hampshire	31099	241.54
Tennessee	158041	240.03
Connecticut	102335	230.11
New Jersey	234389	224.54
California	685159	220.87
Indiana	153606	211.63
Montana	23527	210.66
Delaware	17458	210.06
Oklahoma	88630	206.39
South Carolina	84568	203.08
North Dakota	19064	200.82
Idaho	24852	199.43
Georgia	137585	198.56
Wyoming	9497	195.88
New Mexico	31743	191.41
Wisconsin	129803	189.21
Vermont	13251	186.91
Florida	413100	185.96
Illinois	266326	182.11
Kentucky	92054	180.54
Maine	29419	167.94
Ohio	245545	167.18
Michigan	195707	166.37
North Carolina	135149	160.61
Colorado	53201	160.04
Nebraska	36169	158.31
Oregon	62531	156.54
Virginia	103701	153.60
Utah	22352	151.12
Alaska	3210	148.15
West Virginia	42907	145.19
Texas	249684	145.12
Louisiana	71444	142.93
Mississippi	49114	140.16
Washington	80769	139.88
Maryland	59558	118.18
Kansas	41067	117.63
Hawaii	12525	108.01
Minnesota	56326	99.98
New York	219386	92.03
Arizona	38655	83.45
Puerto Rico/Virgin Islands	19163	67.92
Iowa	25774	58.30
Nevada	6497	52.10
Arkansas	16983	45.43
South Dakota	3393	32.15
U.S. Total	5612275	182.56

RELATIVE VALUE UNITS FOR RADIATION ONCOLOGY PROCEDURES

From Medicare (1989 BMAD)
15:52 Wednesday, October 23, 1991
ALL PLACES OF SERVICE

STATE	Total RVUs	RVUs per Enrollee
Missouri	2258272	3.02
California	8299321	2.67
Washington	1258108	2.17
Georgia	1461133	2.10
Alabama	1154455	2.08
Nevada	255323	2.04
Pennsylvania	3811654	2.04
Louisiana	985446	1.97
Florida	4297356	1.93
Arizona	894296	1.93
North Dakota	163938	1.72
Kentucky	862837	1.69
Montana	180307	1.61
Arkansas	574319	1.53
Illinois	1869249	1.27
South Dakota	133955	1.26
Utah	185098	1.25
South Carolina	505164	1.21
Indiana	854101	1.17
Oklahoma	503415	1.17
Tennessee	766419	1.16
North Carolina	959043	1.13
Ohio	1644557	1.11
New Jersey	1162006	1.11
New York	2616523	1.09
West Virginia	315600	1.06
Maryland	538049	1.06
Wisconsin	731550	1.06
Nebraska	213140	0.93
Connecticut	414326	0.93
New Mexico	154283	0.93
Idaho	115347	0.92
Oregon	355170	0.88
Mississippi	308253	0.87
Michigan	1012206	0.86
New Hampshire	103837	0.80
Delaware	64465	0.77
Virginia	518515	0.76
Texas	1286539	0.74
Puerto Rico/Virgin Islands	207657	0.73
Iowa	319633	0.72
Colorado	239834	0.72
Minnesota	385551	0.68
Wyoming	32839	0.67
Vermont	46222	0.65
Maine	106691	0.60
Alaska	12599	0.58
Kansas	183706	0.52
Hawaii	45829	0.39
U.S. Total	45368159	1.47

RELATIVE VALUE UNITS FOR RADIATION ONCOLOGY PROCEDURES

From Medicare (1989 BMAD)
15:52 Wednesday, October 23, 1991
HOSPITAL INPATIENT & OUTPATIENT ONLY

STATE	Total RVUs	RVUs per Enrollee
Missouri	1156694	1.54
Alabama	782402	1.41
Pennsylvania	1774243	0.95
Tennessee	604825	0.91
Connecticut	374356	0.84
New Jersey	853356	0.81
New Hampshire	103643	0.80
North Dakota	76358	0.80
Indiana	564371	0.77
California	2397335	0.77
Florida	1709107	0.76
Idaho	95836	0.76
New Mexico	127243	0.76
Montana	84864	0.75
Oklahoma	324953	0.75
Delaware	62669	0.75
South Carolina	309511	0.74
Georgia	513460	0.74
Kentucky	371591	0.72
Wisconsin	491935	0.71
Michigan	810565	0.68
Wyoming	32839	0.67
Illinois	967571	0.66
Vermont	46222	0.65
Ohio	907377	0.61
Maine	106497	0.60
Louisiana	302374	0.60
Utah	88522	0.59
Nebraska	135920	0.59
Virginia	400801	0.59
Colorado	196017	0.58
North Carolina	493627	0.58
Mississippi	201703	0.57
Oregon	225365	0.56
Alaska	12042	0.55
Texas	932194	0.54
Washington	310921	0.53
Maryland	253659	0.50
West Virginia	146629	0.49
Kansas	158575	0.45
Hawaii	44252	0.38
New York	865779	0.36
Arizona	166932	0.36
Minnesota	196156	0.34
Iowa	101144	0.22
Puerto Rico/Virgin Islands	57631	0.20
Arkansas	66825	0.17
Nevada	21595	0.17
South Dakota	12455	0.11
U.S. Total	21040965	0.68

RELATIVE VALUE UNITS FOR RADIATION ONCOLOGY PROCEDURES

From Medicare (1989 BMAD)
15:52 Wednesday, October 23, 1991
OFFICE & CENTERS ONLY

STATE	Total RVUs	RVUs per Enrollee
California	5901986	1.90
Nevada	233727	1.87
Washington	947187	1.64
Arizona	727364	1.57
Missouri	1101577	1.47
Georgia	947673	1.36
Louisiana	683071	1.36
Arkansas	507493	1.35
Florida	2588248	1.16
South Dakota	121500	1.15
Pennsylvania	2037410	1.09
Kentucky	491246	0.96
North Dakota	87579	0.92
Montana	95442	0.85
New York	1750744	0.73
Alabama	372052	0.67
Utah	96575	0.65
Illinois	901677	0.61
West Virginia	168971	0.57
Maryland	284390	0.56
North Carolina	465416	0.55
Puerto Rico/Virgin Islands	150025	0.53
Ohio	737179	0.50
Iowa	218488	0.49
South Carolina	195652	0.46
Oklahoma	178462	0.41
Indiana	289730	0.39
Wisconsin	239615	0.34
Nebraska	77220	0.33
Minnesota	189395	0.33
Oregon	129805	0.32
Mississippi	106550	0.30
New Jersey	308650	0.29
Tennessee	161593	0.24
Texas	354345	0.20
Virginia	117714	0.17
Michigan	201640	0.17
New Mexico	27039	0.16
Idaho	19510	0.15
Colorado	43817	0.13
Connecticut	39970	0.08
Kansas	25130	0.07
Alaska	556	0.02
Delaware	1795	0.02
Hawaii	1577	0.01
New Hampshire	194	0.00
Maine	194	0.00
U.S. Total	24327194	0.79

Enclosure D.

acr

October 23, 1991

James G. Schwade, M.D.
University of Miami School
of Medicine
P.O. Box 016960
Miami, FL 33101

Dear Dr. Schwade:

We are pleased to offer this analysis of the effect of joint ventures on the volume of services in freestanding radiation therapy centers in Florida. This analysis is an important supplement to the Cost Containment Board's Volume II study of joint ventures. That study looks at the operations and characteristics of health care entities to which patients can be referred. In essence, it examines these entities from *inside* and so does not study how the flow of patients to them depends on whether on not referring physicians have a financial interest in the entities to which they refer. However, many studies of financial interest and self-referral find that an elevated level of referrals is a major result of financial interest. (See, for example, the attached article from the *New England Journal of Medicine* dealing with diagnostic radiology.) Thus it is important to be able to examine the volume of services in the context of joint ventures and self-referral.

We do this by comparing the volume of radiation therapy services per Medicare enrollee in Florida with that in other states. The methodology is very similar to that which was presented to the Cost Containment Board by the Center for Health Policy Studies when the Board met in late September to consider the Volume II study.

Critical to the analysis is the fact that referring physicians with a financial interest in the freestanding radiation therapy center to which they refer are much more common in Florida than elsewhere. The American College of Radiology's 1989 Group Practice Survey found that, nationally, 7 percent of freestanding radiation therapy centers had this sort of financial arrangement. You have informed us that 13 of the 23 Florida centers in the Board's survey, or 57 percent, had it. Both percentages are subject to some uncertainty because they are based on samples, but the figure for Florida is clearly much higher.

(Note that the Volume II report uses a different definition of joint venture, a definition under which any physician ownership makes an entity a joint venture. This definition would, inappropriately, treat a freestanding radiation therapy center fully owned by the radiation oncologists who worked there as a joint venture. In fact, this is a normal physician's office. The potential for abuse arises when a referring physician has a financial interest in a facility or service to which he can refer patients.)

Because many more Florida radiation therapy centers have this potentially abusive arrangement, one can estimate its effect by comparing the volume of radiation therapy services per Medicare enrollee in Florida with the volume elsewhere in the U.S. The essence of this comparison appears in the attached table; details are in the following three

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computer printout pages. We use data for the Medicare population because standardized Medicare data are available for the nation and because the Medicare population is the elderly population of the U.S. Because cancer, the disease for which radiation therapy is used, is very much a disease of the elderly, it is more meaningful to study radiation therapy services relative to the elderly population than relative to the entire population.

In brief, the finding is that in freestanding centers, there were approximately 52 percent more radiation therapy procedures per Medicare enrollee in Florida than in the U.S. as a whole. Naturally enough, the question arises whether this occurs because Florida has relatively little radiation therapy done at hospitals, with centers having partially substituted for hospitals. The table shows this is not the case. Florida is very close to the national average for radiation therapy performed at hospitals. Thus, the appropriate conclusion seems to be that joint ventures have raised the number of radiation therapy procedures done at freestanding centers by about 50 percent and, as a result, the total number of procedures (including those at centers and those at hospitals) is elevated by approximately 20 percent. As a consequence, Florida ranks high --sixth among the states--in radiation therapy procedures per Medicare enrollee.

We have conducted a similar analysis in terms of relative value units (RVUs), with the relative values taken from Medicare's radiology relative value scale. RVUs have an advantage over a simple count of procedures: They distinguish appropriately between greater and lesser procedures, rather than counting all procedures equally.

Findings of the RVU analysis are much the same, as the attached table and printouts show. Per Medicare enrollee, RVUs associated with radiation therapy procedures in freestanding centers were about 50 percent higher than the national average in Florida. There was no below-average level of services at hospitals that would account for this.

I hope these analyses are informative.

Sincerely,

Jonathan Sunshine

Jonathan Sunshine, Ph.D.
Director of Research

Chairman STARK. Thank you.

Dr. Moffat.

STATEMENT OF MARILYN MOFFAT, PH.D., PRESIDENT, AMERICAN PHYSICAL THERAPY ASSOCIATION

Ms. MOFFAT. Thank you, Mr. Stark, Mr. Gradison.

My name is Dr. Marilyn Moffat, and I am president of the American Physical Therapy Association.

On behalf of the 51,000 members of the association, and the more than 5,000 members of our private practice section, I am pleased to share with you our strong opposition to physician referral for profit, and in particular, to physician self-referral for physical therapy services.

The American Physical Therapy Association has opposed referral for profit since 1985, when our house of delegates adopted its current policy. Unfortunately, the evidence indicates that these referral for profit arrangements and the conflicts of interest inherent in them are increasing.

The economic reality of the 1980s and the 1990s is that referring practitioners have become entrepreneurial, and are seeing ways to protect or increase their income. Health care has become a business, and patients increasingly are treated as a commodity.

Several examples illustrate the problem for physical therapy.

A "business plan" was sent out nationwide to orthopedists, which pointed out that most of them were probably noting a marked decline in their income. The plan explained how these physicians could receive an additional $30,000 to $50,000 a year that they had been sending to their competition. The solution was investment in a physician-owned physical therapy clinic. Being a partner in their own physical therapy clinic would not only generate income but, for tax purposes, it would be passive income which could be "offset by any passive losses incurred from other past investment activities."

A second example was a "dear colleague" letter sent to physicians, describing a similar opportunity. In this instance, a network of outpatient physical therapy clinics was being developed, each to be owned by 12 to 20 doctors as limited partners.

Despite any disclaimers to the contrary, the common thread in these and other similar deals is the income potential. Unfortunately, we are faced with circumstances where the potential of referrals is as good as gold, even to the point where physicians may contribute their ability to refer patients in place of investment capital, and expect an income in return.

A desire to increase one's income should not be a consideration in a physician's referrals to physical therapy services. Even more important is the APTAs belief that referral-for-profit creates a serious potential for abuse in the provision of physical therapy through overutilization. The wider the range of nonphysician services added to a physician's practice, the greater the opportunity for inappropriate self-dealing, and the wider the range of services offered by the physician or physician-owned company, the greater the physician's incentive to order those services.

Studies have indicated that ownership or investment by referring physicians in other health care services leads to much higher utilization of these services. These studies are cited in the 1986 Institute of Medicine's report entitled, "For-Profit Enterprise in Health Care," which is detailed in our written testimony.

They demonstrate, as does the Office of the Inspector General's report, submitted to Congress in May of 1989, that investments and other economic arrangements which rewards referring practitioners financially for making referrals do, in fact, influence them to make referrals.

The resulting impact on the utilization and cost of health care services is inescapably detrimental to both patients and health care payers. This adverse impact has been shown to affect physical therapy services. The Florida Health Care Cost Containment Board study specifically reported that over 95 percent of the physicians who invested in physical therapy services were in a position to refer patients to those services, and that physician-owned physical therapy services, one, provided 43 percent more visits per patient than other physical therapy centers; two, generated approximately 31 percent more revenue per patient; three, rendered about 40 percent more visits per full-time equivalent licensed physical therapist; four, provided more of their care by substituting nonlicensed workers for licensed practitioners; and five, concentrated on providing services to the better insured, and thus more lucrative clientele.

Referral-for-profit is a special problem to physical therapists, because physical therapy licensing laws in many States require a physician referral as a prerequisite to the delivery of physical therapy. This problem is exacerbated by Medicare law, which requires a physician referral in every State, even where the legislature has specifically acted to remove this requirement.

This creates what the Florida study characterizes as "a captive referral system" which inhibits competition. In effect, referring physicians control the demand for physical therapy services, and then position themselves exclusively to supply that demand. Competition by independent practitioners is totally eliminated, and a captive market is enjoyed at what has been demonstrated, again, to be considerable expense to patients and payers.

As long as physician referrals are required, and as long as physicians are permitted to invest in services to which they refer, again, no semblance of competition exists.

Those physical therapists who choose not to have some financial arrangement with a referring physician experience steadily diminishing referrals, or even worse, lose their entire practice as more physicians grab a piece of the pie and monopolize the supply for which they are certifying the demand.

Mr. Shauf will provide examples of the negative impact of physician self-referral in a moment.

Our health care system places physicians in the role of gatekeepers. As such, they have a critical fiduciary role, where the very least that consumers should expect is that they will not be subject to self-dealing to the advantage of their fiduciary.

To finish this testimony, I should like to just ask you to take a moment to reflect on the fact that at one point or another in our lives you, or some family member, is likely to be in need of physical therapy services. When this occurs, I know I would want my physician's recommendation of a physical therapist to be based solely on that physical therapist's competence, and other factors geared toward meeting my physical therapy needs, rather than the physician's opportunity to earn income from the therapist's services. I believe you would feel the same way. Physician ownership is not necessary for physical therapy services, and is an intolerable abuse of the physician-patient relationship.

The American Physical Therapy Association urges Congress to act to protect both Medicare beneficiaries and the trust fund, by prohibiting referral-for-profit and, in so doing, to provide the States with a blueprint for action which may be applied across the country. The American Physical Therapy Association appreciates this opportunity to present our concerns, and we look forward to assisting in any way possible to help put an end to these unnecessary and abusive practices.

Thank you.

[The prepared statement and attachments follow:]

apta American Physical Therapy Association
1111 North Fairfax Street, Alexandria, Virginia 22314-1488 (703) 684-2782 • FAX (703) 684-7343

Statement of Marilyn Moffat, PT, PhD, FAPTA
President, American Physical Therapy Association
Before a Joint Hearing of the Subcommittee on
Health and the Subcommittee on Oversight,
Committee on Ways and Means
Concerning Physician Ownership/Referral Arrangements
October 17, 1991

On behalf of the over 51,000 physical therapist, physical therapist assistant and physical therapy student members of the American Physical Therapy Association (APTA), I am most pleased to have this opportunity to share with members of the House Ways and Means Committee's Subcommittees on Health and Oversight our strong opposition to physician "referral for profit" and, in particular, to physician "self-referral" for physical therapy services. I am also very pleased to represent the more than 5000 members of our Private Practice Section.

The APTA has long held a position opposing referral for profit. In 1985 our House of Delegates adopted the following policy dealing with this issue:

> "No referring practitioner should bill or be paid for a service which (s)he does not perform; mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received. The Association believes that these arrangements offer a serious potential for abuse in the provision of physical therapy. The Association further believes that the effective provision of physical therapy will be enhanced if such arrangements are avoided."

Over the years the Association has expended substantial effort to discourage the proliferation of referral for profit arrangements.

Unfortunately, the evidence indicates that referral for profit arrangements and the inherent conflicts of interest they represent are increasing. The recently released Volume II of the State of Florida Health Care Cost Containment Board's report on Joint Ventures Among Health Care Providers in Florida concludes at the end of its first chapter that "physician ownership of ancillary services is quite common in Florida. Further, most of these physician owners are specialists who are in a position to refer their patients to the facilities in which they have an investment interest." One key part of the Florida study concentrated on the provision of physical therapy services. The results are disturbing to anyone who is concerned about the direction of American health care.

With an impressive 83.7% response rate among the facilities surveyed, nearly 40% of the responding providers of physical therapy services indicated physician ownership. The study further indicated that over 95% of the physicians who invested in physical therapy services were in a position to refer patients to those services.

What then is the overwhelming attraction of physical therapy services to referring physicians? An economic reality of the late 1980's and early 1990's is that referring practitioners are becoming more entrepreneurial and are seeking ways in which to protect or increase their income. The bottom line is that health care is becoming more and more a business, and that patients increasingly are being treated as a commodity.

The examples are many, but several will serve to illustrate the problem in the context of physical therapy. A "business plan" was sent out to a number of orthopedic surgeons around the country which began by stating that most of them were probably noting "a marked decline in your income during the last year or so." The plan proceeded to explain how these physicians could "receive an additional thirty to fifty thousand dollars a year that you have been sending on to your competition..." the planned solution turned out to be a physician-owned physical therapy clinic in which the orthopedic surgeon had an opportunity to invest. The plan further noted that these surgeons were "probably in the 38.5% marginal income tax bracket" and that this "means that out of every dollar you earn, you must pay almost forty cents in taxes." "Being a partner in your own physical therapy clinic would generate passive income," the plan explained, "and, as such, could be offset by any passive losses you may have incurred from other past investment activities." "This in effect," it was further asserted, "amounts to Legitimate Tax Free Income" (Appendix A). Thus, it is clear that referral for profit is being promoted not only as a means to earn additional income, but as a way to obtain favorable tax treatment as well.

As a second example, a "Dear Colleague" letter sent to physicians described a similar opportunity. In this instance a network of outpatient physical therapy clinics was being developed, each to be owned by 12 to 20 doctors as limited partners. This letter noted that "Minimal cash investment by doctors is necessary since the clinic is more interested in patient referrals from doctors" (Appendix B).

In yet a third example, a doctor wrote to his colleagues that "In spite of having my own physical therapy unit for years, at least half of my patients have been referred to physical therapy facilities out of my control. I have lost much potential income from these outside referrals." He then described the network he was promoting and urged his colleagues to "Please open your mind up to this potentially wonderful situation. No investment on your part is required. However, you can have an additional source of income that is under your control" (Appendix C).

Despite any disclaimers to the contrary, the common thread which ties these descriptions of opportunities together is the income potential on which the appeals are based.

Unfortunately, we are faced with circumstances where patients are regarded as commodities and where the potential of referrals is as good as gold, even to the point where a physician may contribute his ability to refer patients in place of investment capital, and expect an income in return.

The APTA strongly believes that a desire to increase one's income should not be a consideration when physician refers for services such as physical therapy. Even more important, however, is the APTA's belief that referral for profit creates a serious potential for abuse in the provision of physical therapy. One critical way in which abuse can occur is through overutilization. While a certain threshold of conflict of interest cannot be eliminated from our traditional fee for services system of health care, it is only a matter of common sense that the wider the range of services added to a physician's practice the greater the opportunity for additional self-dealing. By the same token, the wider the range of services offered by the physician or through a physician-owned company, the greater the physician's incentive to order these services. A reasonable line which both the Florida report, and APTA's experience nationwide, suggest needs to be drawn is to prohibit referrals by a physician with an ownership interest in the entity to which the referral is made

Several studies point to the fact that ownership or investment by referring physicians in other health care services leads to much higher utilization of these services. These studies are cited in a 1986 report of the Institute of Medicine entitled For-Profit Enterprise in Health Care.

For example, studies on laboratory use show a direct relationship between physician ownership and utilization. One study done in 1983 by HCFA Region V found that average per-patient reimbursement was 34% higher in laboratories in which primary physicians had an ownership interest than in "nonpractice-related laboratories," both because of higher prices and higher utilization levels. That Region V study also cited a 1981 study by the Blue Cross/Blue Shield of Michigan which found that physician practice-related laboratories averaged 14.16 services per patient as compared with 9.94 services per patient in nonpractice-related laboratories. Similarly, a small study of six laboratories by the Michigan Medical Services Administration found that patients referred by physicians who had ownership interests in the laboratories had 41 percent more tests ordered than did patients referred by nonowners. These findings were reinforced by a report from the Office of Inspector General submitted to Congress in May 1989.

These several examples support the conclusion that investments and other economic arrangements which reward referring practitioners financially for making patient referrals do in fact influence them to make referrals. The resulting impact on the utilization and cost of health care services is inescapably detrimental to both patients and health care payors.

This adverse impact has been shown to affect physical therapy services as well. The Florida study specifically reports that physician-owned physical therapy centers provided 43% more visits per patient than other physical therapy centers, generating approximately 31% more revenue per patient. The Florida study also examined physical therapy services which are delivered in comprehensive rehabilitation facilities and found that, in this setting, 35% more physical therapy visits were provided per patient when the facility was physician-owned. These 35% more visits generated approximately 10% more revenue per patient.

Two possible justifications might be advanced for the significantly higher utilization and cost of care in the physician-owned settings. First, one might assume that higher utilization and costs reflect a higher quality of care. However the Florida study indicates that this was not the case.

The pattern which emerges when the number of visits are expressed relative to the sum of full time equivalent licensed physical therapists and physical therapist assistants is that facilities with physician ownership rendered about 40% more visits per full time equivalent licensed physical therapy practitioner than did other facilities. In addition, the study found a tendency in the physician-owned physical therapy centers to provide care by substituting nonlicensed medical workers for licensed practitioners. According to the study, "These findings indicate that joint venture (i.e., ventures with physician ownership) physical therapy centers provide a lower quality of care because both licensed therapy workers and nonlicensed workers spend less time with each patient."

The study's conclusion was even more striking in the context of comprehensive rehabilitation centers. In those settings, the number of physical therapy visits per full time equivalent licensed physical therapist and full time equivalent licensed physical therapist assistant was 53% more in physician-owned facilities than in other facilities.

Despite the significantly higher resulting cost, and possible decrease in quality, it has been argued that another justification for physician investment might be that physician ownership is a means of providing wider access to physical therapy services.

However, the Florida study also found that this is not the case. The study measured access for various types of patients, categorized by payor group, in terms of the percent of total revenues received from each payor group, and also examined gross revenues attributable to bad debt and charity care. In light of these indicators, the study found that nonphysician-owned physical therapy facilities received significantly more of their revenues from patients covered by public payors than physician-owned physical therapy centers. The study also found that nonphysician-owned centers wrote off significantly more of their gross revenues as bad debt and charity care. In other words, instead of providing wider access, the physician-owned facilities essentially concentrated on providing services to a better-insured and, thus, more lucrative clientele. Findings were similar in the context of comprehensive rehabilitation facilities.

Thus, the evidence does not indicate that access to physical therapy services is improved by physician ownership. To the contrary, a broader spectrum of clients is served by the nonphysician-owned facilities.

Finally, referral for profit is a special problem for physical therapists because of the fact that in Florida, 23 other States, the District of Columbia, and Puerto Rico, state licensing laws governing the practice of physical therapy require physician referral as a prerequisite to the delivery of physical therapy services. This problem is exacerbated by the Medicare law and regulations which impose the requirement of physician referral across the board, even in those 26 states where the legislatures have specifically acted to remove that requirement from their physical therapy practice acts. This creates what the Florida study characterizes as "a captive referral system which inhibits competition by non-joint venture providers."

The practical effect of this captive referral system is that physical therapists are sent the unmistakable message that to maintain a viable practice it is necessary for them to affiliate with a referring physician. Those who do not will increasingly lose the referrals which they necessarily must have in order to treat patients. The situation becomes one in which the referring physician controls the demand for physical therapy services, and then positions himself or herself exclusively to supply that demand. The end result is the elimination of competition by independent practitioners, and the enjoyment of a captive market at what has been demonstrated by the Florida study to be a considerable expense to both patients and payors.

In short, as long as physician referral is required and as long as physicians are permitted to invest in services to which they refer, there can be no semblance of competition. Those physical therapists who choose not to have some financial arrangement with a referring physician will experience steadily diminishing referrals as more and more physicians decide to grab a piece of the pie and monopolize the supply for which they are certifying the demand.

In conclusion, it is beyond dispute that our current health care system places the physician in the role of gatekeeper. As such, physicians have a critical fiduciary role where the very least that consumers should be able to expect is that they will not be subject to self-dealing to the advantage of their fiduciary. Unfortunately, consumers are increasingly disappointed in that expectation as they encounter repeated examples of self-dealing which cannot help but raise questions as to whose interests are being served.

The APTA urges Congress to act to prohibit referral for profit and in so doing to provide the states with a blueprint for action which can be applied beyond the Medicare and Medicaid programs to the larger world of health care delivery in general.

The APTA appreciates this opportunity to present our concerns and we look forward to assisting in any way possible to help put an end to these unnecessary and abusive practices.

APPENDIX A

NATIONAL PHYSICAL THERAPY
MANAGEMENT, INC.
11767 KATY FREEWAY, SUITE 964
HOUSTON, TEXAS 77079
(713) 497-8961

November 23, 1988

Ref: New Profit Center for Your Practice

Dear Doctor Cress,

If you are typical of the doctors we talk with, you have probably noticed a marked decline in your income during the last year or so. We are also sure that you are as familiar as we are with the reasons why this has occurred. With the increase in competition within the medical field, changes in Medicare and Medicaid reimbursements, cuts in private insurance payments and workers compensation payments being reduced by the insurance companies, this situation is not going to get any better. More important and to the point, as an orthopedic surgeon there is something you can do about it!

We know your first priority is to provide the finest care possible for your patients! If you would like to know how you can provide this standard of care for your patients that need physical therapy and receive an additional thirty to fifty thousand dollars a year that you have been sending to your competition, that's right, your competition, read on.

The American Physical Therapy Association has been actively campaigning to allow physical therapists to treat patients without a doctors prescription! Fortunately this aggressive approach to interfering with the doctor-patient relationship has not yet been approved in all states, but twenty-one states have approved it and others have it under consideration. We at National Physical Therapy Management, Inc. don't believe that physical therapists should be allowed to practice medicine. We don't believe that this is good for the patient, good for the doctor, or even good for the physical therapists and we do not allow patients to be treated at any of the clinics with which we are affiliated without a prescription from a licensed physician.

Doctor Cress; physician owned physical therapy clinics are nothing new. If you are not referring your patients to your own clinic, you may already be referring them unknowingly to another physician owned clinic, with all the attendant disadvantages.

By the way, your participation in a business venture structured as these physical therapy clinics are organized will not conflict with the Medical Practice Act of any state or compromise the ethics of your profession.

As the saying goes, "You can lead a horse to water, but you can't make him drink." If, at this point, you are still not interested in adding $30,000.00 to $50,000.00 a year (that's $2500.00 to $4000.00 a month) to your personal income, there is not much else we can say. Except, you probably don't have enought information to make a rational decision.

In closing however, we will leave you with this thought: You are probably in the 38.5% marginal income tax bracket, which means that out of every dollar you earn, you must pay almost forty cents in taxes. The profits that you would earn as a partner in your own physical therapy clinic would be passive income and, as such, could be offset by any passive losses you may have incurred from other past investment activities. This, in effect, amounts to Legitimate Tax Free Income.

Check it out with your accountant, if you like, and if you are ready to exercise more control over your patients physical therapy treatments and receive a substantial increase in your income, return the enclosed card for additional information and let us show you how we can have your clinic in operation in ninety days or less.

Sincerely,

John Marr

John Marr,
Director of Clinic Development

JM:hp

ROLL OF THE GENERAL PARTNER

Development of all legal documentation related to the formation of the clinic.

* Prearranged financing
* Site selection and design of the center.
* Coordinate start up of center
* Supervision of contractor and leasehold improvements.
* Physician recruitment, if necessary, to insure a workable operation.

Provide corporate professional services:

* Marketing of center services
* Billing and collection
* Computerized electronic insurance claim filing
* Computerized accounting systems and accounting functions
* Yearly planning and budgeting
* Preparation of operational and financial reports
* Staff recruitment, evaluation and training
* Continuous hands on management
* Financial responsibility for equipment leasing
* Financial responsibility for space leasing
* **MAKING IT WORK !**

BENEFITS TO THE LIMITED PARTNERS

* Participation as owners in a new therapy center.

* An investment opportunity with a quick start up and a return of your investment anticipated during the first year.

* Small investment.
  Limited partners receive 100% of profits until they have received profits equal to their investment cost.

* Investment is effectively used. NO DEBT, NO REAL ESTATE, NO CAPITAL GOODS, ONLY LEASED EQUIPMENT.

* The center will be well located, designed, decorated, equipped and managed.

* Treatment will be the best available and prices reasonable.

* Limited financial liability (Your original investment).

* NO ADDITIONAL MALPRACTICE LIABILITY.

* No managerial or supervisory responsibility.

* National Physical Therapy Management, Inc Trained clinic staff. All clinic personnel receive training at our proto type clinic in Houston, Texas in both business and medical protocols before being assigned to your clinic. This training is followed up with continuing education and in-service workshops and seminars to assure a continuity of service compatible with National Physical Therapy Management, Inc. standards of practice.

SERVICES THE CENTER PROVIDES

* Physical therapy.

* Sports medicine.

* Diagnostic evaluation related to musculo/skeletal problems including computerized isokinetics and ergometry .

* Pain treatment (TENS).

FINANCIAL STRUCTURE OF CENTERS

The limited partners each make a onetime investment. They own 80% of the partnership. The general partner owns 20% of the partnership in exchange for contributing 20% of the capital and setting up and operating the partnership and assuming ALL LIABILITY for the space and equipment leases, which typically aggregates $300,000.00 plus.

REVENUE ASSUMPTIONS:

Full revenue potential is expected to be reached by the end of the seventh month, with the second year revenue being approximately equal to the seventh month multiplied by 12.

OPERATING EXPENSES:

Staff:

1 Licensed Physical Therapist
2 Licensed Physical Therapy Assistant
2 Physical Therapy Aid
1 Administrator
1 Receptionist/Medical Transcriptionist
billing clerk

Benefits are assumed to be 10% and payroll taxes 7% of payroll

Space:

Approximately 3500 sq/ft on a five (5) year lease

Equipment lease:

Cost of equipment approximately $105,000.00 on a five (5) year lease

START UP COST:

Furniture & Accessories
Space Lease Security Payment
Computer Equipment & Software
Recruitment of Personnel
Office Equipment & Supplies
Linens
Miscellaneous

REFERRAL ASSUMPTIONS:

Each partner refers 2 new patients for therapy each week.
Average visits per patients, 12 at $74.65/visit
Net Each Partner, $3,077.00 Monthly, or $36,926.00 Annually

Each partner refers 3 new patients for therapy each week.
Average visits per patients, 12 at $74.65/visit
Net Each Partner, $5,223.00 Monthly, or $62,675.00 Annually

Each partner refers 4 new patients for therapy each week.
Average visits per patients, 12 at $74.65/visit
Net Each Partner, $6,877.00 Monthly, or $82,523.00 Annually

Each partner refers 5 new patients for therapy each week.
Average visits per patients, 12 at $74.65/visit
Net Each Partner, $8,523.00 Monthly, or $102,272.00 Annually

National Physical Therapy Management, Inc. can have your clinic in operation 90 days after completing the paperwork.

> The Clinic will actually show a profit with each partner referring only one (1) new patient each week.

NATIONAL PHYSICAL THERAPY MANAGEMENT, INC

BUSINESS PLAN FOR PHYSICAL THERAPY CENTERS

THIS BUSINESS PLAN IS NOT AN OFFER TO SELL NOR IS IT A SOLICITATION OF AN OFFER TO BUY SHARES IN THIS VENTURE WHICH CAN ONLY BE MADE BY THE MEMORANDUM. IT IS PRESENTED FOR INFORMATION ONLY.

TABLE OF CONTENTS

The Concept 3

National Health Care Industry 7

The Market 9

Marketing 12

The Company 14

Financial Structure of the Centers 17

Statistical Analysis of a Physical Therapy Clinic Started 1/1/87 19

Six Months Income Statement 20

Annualized Income of Referenced Physical Therapy Clinic 21

Graph of first Six Months of Operation 22

National Physical Therapy Management, Inc
1830 Kirkwood, Suite #102
Houston, Texas 77077
(713) 497-8957

THE CONCEPT

Normally if a group of Doctors get together to build a clinic, etc, they are faced with a host of problems, not the least of which is accepting the personal financial liability that goes with the acquisition of land or space for the physical plant and the capital expenditure for equipment or the personal financial liability for leasing the equipment.

Then after they have taken the big step and committed their time and money to the project, all they have to do is show a profit to justify their faith in the planning and proforma.

THE PITFALLS:

The two most common causes of business failure are:

1. Lack of business experience.
2. Insufficient capital

Trying to operate a business the way you operate a medical practice is like rearranging the deck chairs on the Titanic to avoid disaster. In operating a medical practice you have, in effect, a captive audience and unless you do something to change their perspective, there will always be a certain amount of loyalty.

In managing a business however, you do not have this luxury. Unless your patient population can support your physical therapy clinic, and this is unlikely, you are in business. Your success will now depend on attracting other doctor's patients and providing better care at a competitive price than the many other facilities competing for the treatment dollars

Additional problems are some doctors dislike sending their patients to clinics owned by other doctors and Physical Therapist, as a class, object to working for physicians.

THERE IS A BETTER WAY:

National Physical Therapy Management, Inc. will not only invest their own money, but also do the hard work for you and accept the financial liability that goes with it and all you have to do is the thing you do best - The Practice of Medicine.

HERE IS HOW IT WORKS:

National Physical Therapy Management, Inc. contacts one
leading Orthopedic Surgeons or Neurologist in your ar
presents the plan. If you wish to explore the concept furt
meeting will be arranged to present it to your colleagues.

A group of doctors (usually 8 to 12) invest $10,000.00 e
Physical Therapy, Ltd, a Texas limited partnership of whi
will own 75% and National Physical Therapy Management, In
general partner, will invest $10,000.00 and assume all the
cial liability for the space and equipment for the Center a
25%. The Limited Partners only liability is the amount of
they used to purchase their shares and there can be NO
assesments.

To increase the leverage, bank financing has been prearrang
on an "interest only" basis and only a $3,000.00 cash outla
is required.

National Physical Therapy Management, Inc. (NPTMI) will
space for the clinic, Provide the equipment, hire the pe
and manage the day to day operation of the facility. It is
tention to provide the best possible physical therapy at a
able cost so that you will have no hesitation in sending y
tients to the clinic.

While as a Limited Partner, you can not participate in the
management of the clinic (or you will lose your status as
ited partner and thereby your limited liability) but, your
will be solicited on medical matters to insure that the
will continue to provide the best possible patient care.

Income from the Center will, according to the IRS, be passi
income and may be offset by any passive losses you may n
have been able to use from other investments. Please che
with your accountant to verify this information and to see
you have passive losses available to offset Center income.

BENEFITS TO THE LIMITED PARTNERS

- Participation as Owners in a New Therapy Center.
- An Investment Opportunity with a Quick Start Up and a Return of Your Investment Anticipated During the First Year.
- Small Investment of $10,000.00. **(Bank financing, "interest only" has been prearranged, only $3,000.00 cash required).**
- Investment is Effectively Used. NO DEBT, NO REAL ESTATE, NO CAPITAL GOODS, MINIMUM CENTER OWNED EQUIPMENT.
- The Center Will be Well Located, Designed, Decorated, Equipped and Managed.
- Treatment Will be the Best Available and Prices Reasonable.
- Limited Financial Liability (Your Original Investment).
- NO ADDITIONAL MALPRACTICE LIABILITY.
- No Managerial or Supervisory Responsibility.

SERVICES THE CENTER PROVIDES

- Physical and Occupational Therapy. ✓
- Sports Medicine.
- Diagnostic Information Related to Musculo/Skeletal Problems.
- Pain Treatment.
- Therapy for Head and Neck Injury.

ROLL OF THE GENERAL PARTNER

Development of all legal documentation related to the formation of the Limited Partnership.

- Prearranged financing
- Site selection and design of the center.
- Coordinate start up of Center
- Supervision of contractor and leasehold improvements.
- Physician recruitment, if necessary, to insure a workable Limited Partnership.

Provide Corporate Professional Services:

- Marketing of Center services
- Billing and collection
- Computerized electronic insurance claim filing
- Computerized Accounting systems and accounting functions
- Yearly planning and budgeting
- Preparation of operational and financial reports
- Staff recruitment, evaluation and training
- Continuous hands on management
- Finanical responsibility for equipment leasing
- Financial responsibility for space leasing
- **MAKING IT WORK !**

NATIONAL HEALTH CARE INDUSTRY

In the United States, the health care industry is undergoing profound and dynamic changes. Technology, government regulations and economic pressures are forcing a restructuring of the way health care is provided as well as a change in the way the public perceives and values health care. Presently, expenditures in the United States for health care related services represent over 10.5% of the gross national product, equivalent to over $1,300 per person. This represents an increase of over 60% during the prior four years. Medical costs are rising much faster than overall inflation (7.5% in the past year compared with 1.7% for the total Consumer Price Index). In the past year, doctors' fees have risen 7.5%, hospital room rates have risen 5.4%, prescription drugs have risen 8.4%, and non-prescription drugs have risen 4.3%. Moreover, these rates are expected to continue to increase, since the demand for medical care is growing and increasing malpractice insurance rates are driving doctor and hospital bills even higher. This increase constitutes the force behind the changes which are taking place in the health care field.

Health care expenditures have increased from $74.7 billion in 1970 to approximately $395 billion in 1984, with expected growth to $690 billion by 1990. There was an average growth rate of 12.8% from 1970 to 1980 and 12.2% from 1980 to 1984, with an expected overall average annual growth of 9.7% from 1984 to 1990. Of the different cost segments which comprise the health care market, hospital costs are expected to increase the most with an annual compound growth rate of 14.2%.

The Tax Equity and Fiscal Responsibility Act of 1982 ("TEFRA") and Title VI of the Social Security Amendments of 1983 revolutionized the methods of payment for health care for individuals covered by Medicare. The resulting prospective payment system, which utilizes diagnostic related groups ("DRGs") as the basis for payment, has made it financially difficult for many hospitals to expand, to finance new equipment, and in many cases, to achieve adequate financial results from their operations. Federal and state governments are intent on containing health care costs, and are forcing health care institutions to either control their costs or face reimbursement deficits. As a result, and as a way of eliminating fixed costs, hospitals are either establishing service agreements or subcontracting certain services.

Additionally, hospitals, insurance companies, private indu
try, and the general public have a vested interest in ever
occurring in the health care field. As insurance compani
attempt to control the rise in premiums, private indust
will be looking toward controlling its health care for e
ployees, and the general public will be searching for alte
natives which will lower the costs of health care.

As part of the profound changes taking place in the
health care is delivered in the United States, doctors
experiencing pressures from many sides, both public and pr
vate, which are affecting their professional incomes. Th
pressure, which is expected to increase in the future, wi
likely present many private investment opportunities.

THE MARKET

Rehabilitation Market Considerations. A consequence of the life-saving medical advances achieved during the last few decades is that most Americans will eventually suffer some physical limitations. This unpleasant reality will likely be ameliorated as procedures and equipment utilized in physical therapy are developed and as the licensed physical therapists apply modern techniques to assist people in need of physical therapy. A combination of new research and new devices are also helping to make life easier for a growing number of people in need of physical therapy.

It is commonly recognized that to ignore a disability is far more costly than an early, aggressive program of medical therapy that restores the individual to the highest possible level of physical, economic, social and emotional self-sufficiency.

Present Need. It has been estimated that 15% of the working-age population are limited in their ability to work because of chronic health conditions and impairments. There are thought to be 20 million arthritics, and those with neurological disorders may number 1.5 million. It is estimated that each year back pain disabilities affect at least 17.7 million people badly enough to require hospitalization. It is estimated that approximately 70% of the population shall become disabled to the extent of being unable to climb a flight of stairs.

Medical advances, programs for early detection, improvements in health education and prevention of disabling conditions will reduce or eliminate many causes of existing physical disabilities, but other causes may develop.

The prevalence of disability will probably increase because of the increasing population and the greater longevity of the population. A major and increasing proportion of the disabled will be elderly.

According to data collected by the Health Care Financing Administration and the National Center for Health Statistics:

> More than 338 million workdays were lost in 1981 as a result of some type of acute health condition. This

was a loss of an average of 3.4 days for each worker the nation.

During 1981, chronic and acute conditions caused an erage of 19.1 days of restricted activity per per and 6.9 bed disability days per person, and an aver of 4.9 school loss days per child between the ages c and 16.

Approximately 5.3 million work-related injuries curred in 1981. About one injury or illness occur for every 12 workers in the private economy dur 1981.

Some 39.2 million workdays were lost because of wc related injuries in 1981. There were 60.4 lost wc days per 100 workers that same year.

At any given point in time, fully 3% of the populat are suffering from a disease or trauma induced disab ity that would respond to physical therapy treatme reducing suffering and enhancing lifestyles.

Referring Doctors. Patients are often referred by Docto Podiatrists, Chiropractors or Oral Surgeons. The referr doctors and physicians are therefore the key to the succ of the Center. The following types of specialties are pot tial users of the Center's services.

- Orthopedic Surgery
- Hand Surgery
- Neurology
- Occupational Medicine
- Rheumatology
- Traumatology

Other users of the Center's services are the following:

- Family Practice
- General Practice
- Internal Medicine
- Nephrology
- Neurosurgery
- Dentistry
- Plastic surgery

Source of Patients. The Center's patients remain under the care of their primary referring physician throughout the course of their treatment. The Center will keep the referring physician informed of the progress of his patient on an on-going basis.

In addition to the referring physicians, other sources of patients for the Center include the following:

- Short term acute care hospitals
- Acute care medical therapy hospitals and hospital units
- Long term hospitals
- Skilled nursing facilities
- Extended care facilities
- Planned retirement communities
- Home health agencies
- Aggregate living communities
- Noncomprehensive outpatient medical therapy programs and centers
- Vocational programs and centers
- State disability programs and centers
- Workers' compensation programs
- Geriatric programs and centers
- Educational and sports organizations
- Health activity centers
- Health maintenance organizations (HMO's)
- Preferred provider organizations (PPO's)
- Insurance Companies
- Claims adjusting and management services
- Self-insured employers
- Personal injury and insurance attorneys
- Special interest community groups
- General population injuries

MARKETING OF THE CENTERS'S SERVICES

The Center's services will be marketed through the staff and the owner doctors of the Center and through the efforts of the General Partner.

Each staff member needs to make a marketing effort in their area by communicating to interested parties the benefits available at the Center.

COMPETITION

The physical therapy services market is highly competitive. The Partnership's ability to compete depends on numerous factors, including, among others, price of services, quality of services, reliability, performance and product support. The General Partner believes that the Partnership will compete on the basis of quality of services, reliability, functionally and support of its products. The General Partner also believes that the physical therapy services market is very lucrative and has attracted and will continue to attract many different providers of health care.

It is anticipated that the Center will face competition from numerous sources including, but not limited to the following:

> Local hospitals, doctors and private practice therapists;
>
> Specialty local and national providers of narrow-range services such as sports medicine, cardiac medical therapy and back pain management;

Insurance. The Partnership intends to maintain liability insurance sufficient to cover its risks. The General Partner believes that the amounts and coverages of the intended insurance should be adequate for the Partnership's business operations.

Facilities. The Partnership's primary place of business will be a location convenient to the referring Physicians, and their patients.

Personnel. It is anticipated that the staff of the Cente shall consist of the following:

Licensed Physical Therapist (LPT)
Licensed Physical Therapy Aids (LPTA)
Licensed Athletic Trainer (LAT)
Receptionist/bookkeeper/insurance
billing clerk

Additional licensed and unlicensed Physical Therapy Personne can be contracted to fill in as patient load increases.

The LPT, in addition to practicing all the modalities o treatment, is responsible for the evaluation of the patient as well as for the preparation of the written reports to th referring doctors on the advance of treatment of thei patients and for the written reports to insurance companies These professionals not only implement the treatment protocols but also handle the day-to-day administration function and assist with personnel recruitment and marketing. Additionally, the LPT is responsible for the technical educatio of the staff as well as of the patients.

The LPTA can practice all the modalities and exercises on th patients (except for the patients' evaluation) as long as th treatment is under the direct supervision of the LPT. Th LPTAs' main responsibility is to support the LPT in implementing all the treatment programs.

The LAT ~~cannot~~ treat patients but ~~shall~~ provide physical assistance and support to the LPT and LPTAs, such as maintaining the facilities and equipment in good order, helping patients to prepare for treatment and in doing whatever is necessary in support of the operation of the clinic.

THE COMPANY

National Physical Therapy Management, Inc. , a Texas corporation, headquartered in Houston, Texas was formed to provide for doctors a means of setting up physical therapy clinics as a new adjunct to their practice and enable them to receive the benefits of ownership without the financial liabilities and management responsibilities of starting a new business. NPTMI will be the General Partner in the Limited Partnerships used to implement the clinics

A participation in one of NPTMI's physical therapy clinics is designed to provide an opportunity for you to share with your colleagues the advantages of ownership in a new treatment center that, as individuals, you could not justify because of the cost. A small, onetime, transfer of capital from your practice to a jointly owned Physical Therapy Center for a doctor who has a need to refer patients for high quality physical therapy would allow you to share in revenue that you are currently dispersing to others.

Initial capitalization for NPTMI was obtained through sale of common stock to the principals:

John Y. Williamson, President
James T. Parker. Executive Vice President

Clark D McKeever, M.D., Adviser.

The initial funds are being used to pay organization and start-up costs and to provide working capital. The Company intends to organize two additional Clinics during 1987 in Houston, Texas, and seven more clinics in other Texas cities during 1988.

PRINCIPALS:

Mr. Williamson attended the University of Houston and the College for Financial Planning of Denver, Colorado, and is currently continuing his studies in Taxation and Estate Planing.

Entering the securities business in 1966, Mr.Williamson became a New York Stock Exchange Registered Representative and later a Vice-President of the Putnam Management Co. of Boston, Massachusetts and a Registered Principal of the National Association of Securities Dealers. Through out His career in the Securities business, Mr. Williamson's expertise was directed toward financial planning and solving money management problems for businesses and individuals. Additional experience in the field of commercial real estate and real estate syndication allows him to bring a broad knowledge of general business and investments to the challenges of business management.

Mr. Parker attended North Texas State University and has been an independent business man for the past ten years operating his own advertising firm and serving as a computer systems and software consultant for the Entre`Corporation. IBM trained, his experience in computerized accounting systems will enable our centers to take advantage of state of the art advances in business operation and electronic processing of insurance claims.

[redacted]

Clark D. McKeever, M.D. is a Board certified Orthopedic Surgeon and Partner in the McKeever Clinic at The Memorial City Medical Center in Houston, Texas.

National Physical Therapy Management, Inc. has retained the legal firm of I. Ronald Morgan of Houston, Texas who are assisting in the formation and registration of the limited partnerships and who act as legal advisors to the Company.

Patterson & Associates, Certified Public Accountants have been engaged, as the accounting and auditing firm for NPTMI, to examine the financial statements of the Company, to prepare its income tax return and to provide general business advisory services. They will also be used as the accounting firm for the Centers and will prepare quarterly reports and an audited annual report for the partners.

FINANCIAL STRUCTURE OF CENTERS

The Limited Partners each make a onetime investment of $10,000.00 in cash. They receive 75% of the Partnership. The General Partner receives 25% of the Partnership in exchange for investing $10,000.00, setting up and operating the Partnership and assuming ALL LIABILITY for the space and equipment leases, which typically aggregate $ 300,000.00 plus.

REVENUE ASSUMPTIONS:

Full revenue potential is expected to be reached by the end of the seventh month, with the second year revenue being approximately equal to the seventh month multiplied by 12.

OPERATING EXPENSES:

Staff:

1 Licensed Physical Therapist
1 Licensed Physical Therapy Assistant
2 Licensed Physical Therapy Aid
1 Licensed Athletic Trainer (LAT)
2 Receptionist/Medical Transcriptionist billing clerk

Benefits are assumed to be 10% and payroll taxes 7% of payroll

Space:

Aproximately 3000 sq/ft on a five (5) year lease

Equipment lease:

Cost of equipment aproximately $105,000.00 on a five (5) year lease

START UP COST:

Furniture & Accessories
Space Lease Security Payment
Computer Equipment & Software
Recruitment of Personnel
Office Equipment & Supplies
Linens
Miscellaneous

Total expenses vary from about 35% of revenue for 12 doctors to about 40% for 8 doctors

REFERRAL ASSUMPTIONS: *

Each partner refers 4 new patients for therapy each week.
Average visits per patients, 12 at $42.00/visit**
12 Partners, $1,257,984.00 less expenses $503,193.00= $754,970.00
8 Partners, $ 838,656.00 less expenses $335,462.00= $503,193.00
Net to Each Partner, $47,000.00

Each partner refers 3 new patients for therapy each week.
Average visits per patients, 12 at $42.00/visit
12 Partners, $943,488.00 less expenses $377,395.00 = $566,092.00
8 Partners, $628,992.00 less expenses $251,597.00 = $377,395.00
Net to Each Partner, $35,380.00

Each partner refers 2 new patients for therapy each week.
Average visits per patients, 12 at $42.00/visit
12 Partners, $628,992.00 less expenses $251,597.00 = $377,395.00
8 partners, $419,328.00 less expenses $167,731.00 = $251,597.00
Net to Each Partner, $23,587.00

* The Clinic will actually show a profit with each partner referring only one (1) new patient each week.

** $42.00 represents approximately 2/3 of the avgerage patient billing/visit of $63.11 as shown on page 19.

BY AN OPERATING PHYSICAL THERAPY CENTER IN HOUSTON, TEXAS AND IS BELIEVED TO BE ACCURATE, BUT NATIONAL PHYSICAL THERAPY MANAGEMENT, INC, DOES NOT WARRENT OR GUARANTEE IT TO BE. THE PROJECTIONS CONTAINED HEREIN ARE BASED ON THESE NUMBERS AND WHILE WE BELIEVE THEM TO BE REASONABLE, PAST PERFORMANCE IS NOT INDICATIVE OF FUTURE RESULTS WHICH MAY NOT BE THE SAME AS THOSE PRESENTED HERE.

Statistical Analysis of Referenced Physical Therapy Center of Houston

	Patient Visits	Treatment Units	Avg.Units Per Patient	Avg.Unit Charge	Total Billed	Year to date
Jan.	455	833	1.83	21.96	18,299.50	18,299.50
Feb.	953	2,113	2.22	22.59	45,629.25	63,928.75
Mar.	1,260	2,800	2.22	25.28	70,787.50	134,716.25
Apr.	1,811	4,135	2.28	25.68	106,205.00	240,921.25
May	1,543	3,785	2.45	26.78	101,368.00	342,289.25
Jun	1,831	4,312	2.35	27.75	119,671.50	461,960.75
Totals	7,853	17,978	2.29	$25.01	$461,960.75	
Last 3	5,185	12,232	2.36	$26.74	$109,014.30	

Avg. Patient Requires 2.29 Units of Treatment at an Avg. Cost of $25.01/Unit

Using Last Three Months Only:
Avg. Patient Requires 2.36 Units of Treatment at an Avg. Cost of $26.74/Unit

This is an Avg. Billing of $63.11 per Patient Visit

This is an Avg. MONTHLY Billing of: $109,014.30

This is an ANNUAL Billing of: $1,308,171.60

REFERENCED PHYICAL THERAPY CENTER INCOME STATEMENT
PERIOD ENDING : JUNE 30, 1987

	CURRENT	%	YEAR-TO-DATE
INCOME:			
PROFESSIONAL FEES	$110,571.33	100.00%	458,029.58
MISCELLANEOUS INCOME	0.00	0.00%	719.28
TOTAL INCOME	110,571.33	100.00%	458,748.86
COST OF SALES:			
MEDICAL SUPPLIES-RESALE			
MEDICAL SUPPLIES			
PURCHASES			
SALARIES & WAGES			
CONTRACT LABOR			
TOTAL COST OF SALES	11765.62	10.64	74874.26
GROSS PROFIT			
EXPENSES:			
ADVERTISING			
BANK CHARGES			
CONTINUING EDUCATION			
DUES & SUBSCRIPTIONS			
INSURANCE, MEDICAL-GROUP			
INSURANCE, PROF . LIABILITY			
INSURANCE, OTHER			
LEASE, EQUIPMENT			
LEASE , POSTAGE			
LEGAL & ACCOUNTING			
MANAGEMENT FEES			
MISCELLANEOUS			
OFFICE EXPENSE			
POSTAGE			
PRINTING			
RENT			
REPAIRS & MAINTENANCE			
TAXES. PAYROLL			
TAXWS, OTHER			
TELEPHONE			
TELEPHONE, L.D.			
TRANSPORTATION			
TOTAL EXPENSES	20,420.50	18.47%	109,811.54
OPERATING NCOME	78,385.21	70.89%	274,063.06
NET INCOME	78,385.21		274,063.06

The actual dollar value of expens will vary from Center to Center, depending on location, but the ov percentage of expenses to total r should remain reasonable consists

ANNUALIZED TOTAL INCOME *
REFERRENCED PHYSICAL THERAPY CENTER
$917,497.72
PHYSICAL THERAPY, LTD.

GROSS INCOME	917,497.72
EXPENSES	369,371.60
NET PROFIT	548,126.12
NET TO NPTMI	137,031.53
NET TO PARTNERS	411,094.59
EACH PARTNER	34,257.88
RETURN OF CAPITAL	10,000.00
NET/PROFIT EACH PART.	24,257.88

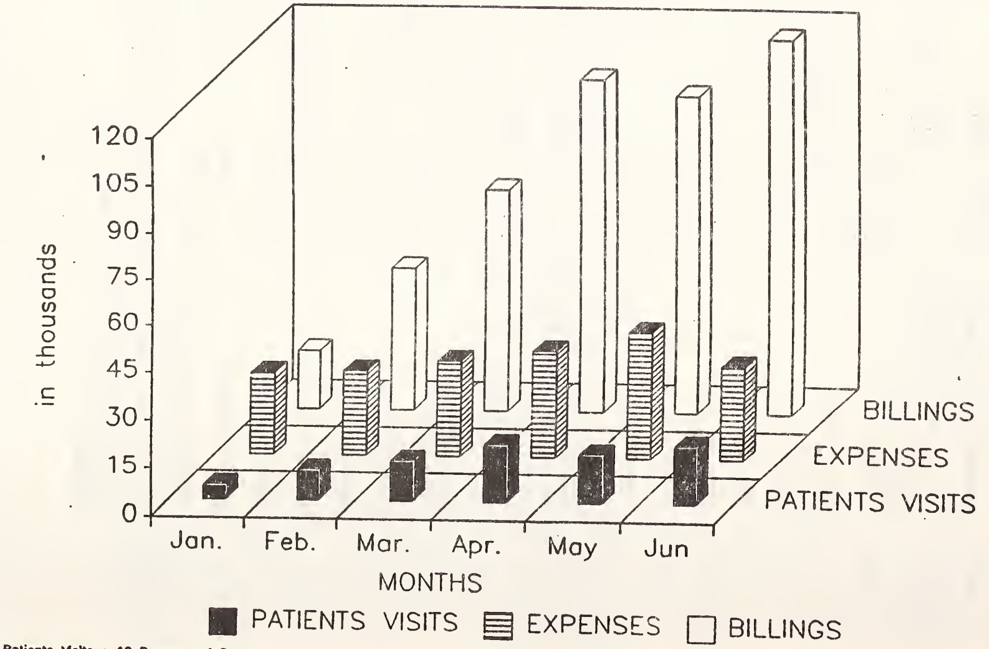
* FIRST SIX MONTHS INCOME ($458,748.86 * 2)
NET PROFIT EQUALS GROSS INCOME LESS
EXPENSES (40.26% BECAUSE OF START-UP COST)

REFERRENCED PHYSICAL THERAPY CENTER
2ND YEAR INCOME ($1,308,171.60) **

GROSS INCOME	1,308,171.60
EXPENSES	457,860.06
NET PROFIT	850,311.54
NET TO NPTMI	212,577.89
NET TO PARTNERS	637,733.66
EACH PARTNER	53,144.47
COST PARTNER	0.00
NET/PROFIT EACH PART.	53,144.47

* * AVERAGE MONTHLY INCOME FROM PAGE 19
($109,014.00 * 12)
NET PROFIT EQUALS GROSS INCOME LESS
EXPENSES (35%)

STATISTICAL ANALYSIS OF PT CENTER



Patients Visits • 10 Because of Scale

APPENDIX B

DOCTORS REHABILITATION
CORPORATION OF AMERICA

Dear Colleague:

The need for doctors to develop a network of out-patient physical therapy centers has become obvious with the increase in out-patient surgical and diagnostic procedures. The benefits to patients (convenience to home or work), and doctors (increased referrals and revenues) becomes evident.. Insurance companies, workman's compensation reimbursement and HMO's have expressed interest in the policy of standardized treatment protocols and fees.

Doctors Rehabilitation Corporation of America (DRCA), a new Houston OTC pink sheet public company, has started developing this network of out-patient physical therapy clinics. Each clinic is owned by 12 to 20 doctors (orthopedic surgeons, family practioners, neurologists, neurosurgeons, plastic surgeons, and podiatrists) as limited partrners with DRCA as the general partner. Minimal cash investment by doctors is necessary since the clinic is more interested in patient referrals from doctors. DRCA contributes money, management, and business systems to run these clinics. Doctors have no responsibility for the financial headaches of management, collections, etc. With DRCA (public stock company) as general partner, doctors (both limited partners and those who are not limited partners) will benefit (via stock ownership) by referring patients to these clinics. The existence of a public company (DRCA) facilitates the recruitment of outstanding physical therapists (salary plus stock options), office personnel, and business managers. The development of these clinics is a Win-Win situation for doctors, patients, insurance ompanies, and plaintiff attorneys (major referral source to clinics).

Many doctors have limited options concerning referral of their patients for out-patient physical therapy. Their choices include:

a). Referral to hospital
b). Referral to private physical therapist clinic
c). Referral to doctor with physical therapy clinic

DRCA provides referring doctors with an outstanding option of clinic ownership (limited partner), stock ownership (purchase stock OTC exchange), or, a combination of both.

DRCA is having an introduction of their new company to the orthopedic surgeons attending the arthroscopic knee meeting in Houston March 11th-14th. Our hospitality suite will be located at:

Guest Quarters Hotel   Hours: 12:00 Noon - 10:00 p.m.
5353 Westheimer Road, Houston, Texas - 961-9000
(One block West, Westin Galleria Hotel)

First clinic (Doctors Medical Therapy Center, Houston I, LTd.) opened five weeks ago. The linic is already treating 65 patients per day. The enthusiasm, and general good feeling among the 12 limited partners is exciting. Arrangements can be made to tour this clinic 12 miles from Galleria). Four additional clinics are in various stages of formation in Houston. DRCA plans to develop 47 clinics (with doctors) in the next 42 months.

Stop by the hospitality suite. I think you will find this project most interesting and profitable.

William F. Donovan, M.D.
President

3 Riverway • Suite 1710 • Houston, Texas 77056 • (713) 439-7511

APPENDIX C

Daniel M. Silver, M.D.
A PROFESSIONAL CORPORATION

WESTWOOD MEDICAL PLAZA
10921 WILSHIRE BOULEVARD • SUITE LL-7
LOS ANGELES, CALIFORNIA 90024
(213) 824-0723

ORTHOPEDIC SURGERY
ARTHROSCOPIC KNEE SURGERY

DIPLOMATE AMERICAN BOARD OF ORTHOPEDIC SURGERY

Dear Dr.

As a colleague interested in protecting my own future, I have become involved in a very interesting project that may be a help in protecting your future also. In spite of having my own physical therapy unit for years, at least half of my patients have been referred to physical therapy facilities out of my control. I have also lost much potential income from these outside referrals. This is no longer necessary in my opinion.

Through a network of physician owned physical therapy clinics throughout the Los Angeles Basin, each of us can have a say in the quality of treatments and ethically bill our own patients for physical therapy services rendered through our facility. Through the hard work and efforts of MedGroup, Inc., (Brit McConkie and Steve Fey) five physical therapy facilities in key locales have been set up with 6 to 8 doctors participating in each one.

In my opinion, the potential of possibly 20-30 locations in the greater Los Angeles area will allow your patients to receive physical therapy no more than 5 minutes from their work or home. Quality therapy will be done in one of their own doctors' facilities. As you probably realize, these elements will have great appeal to your patients. Please open your mind up to this potentially wonderful situation. No investment on your part is required. However, now you can have an additional source of income that is under your control. Hope to see your name as one of the participants. For details call (213) 470-3525.

Sincerely,

Daniel M. Silver

Daniel M. Silver, M.D.

Southland Clinic

Chairman **Stark**. Thank you, Dr. Moffat.

Mr. Shauf.

STATEMENT OF LARRY SHAUF, CHAIRMAN, INDEPENDENT PRIVATE PRACTITIONERS OF PHYSICAL THERAPY

Mr. **Shauf**. Mr. Chairman, members of the committee, my name is Larry Shauf. I am in private practice as a physical therapist in Arlington, Va.

I am here today representing a group known as IPP—Independent Private Practitioners in Physical Therapy. We formed this group 3 years ago, and have members in 46 States. Our aim is to provide data to Federal, State, and local health policymakers, to demonstrate the extent of physician ownership in physical therapy centers, and the impact such ownership and other financial arrangements is having on the cost and the quality of physical therapy services.

The Stark law only prohibits ownership in clinical laboratories. Other areas of ownership were not kept in the statute because there was not enough data to support inclusion. To combat this argument, we formed the IPP group to work with every group in PT, including the APTA, to develop this data.

Mr. Chairman, the findings of members of our network will hopefully demonstrate that the information that led to the prohibition of clinical laboratories is as significant, if not more so, in physical therapy.

Our network members have responded with examples of the magnitude of financial arrangements that physicians and hospitals have in physical therapy centers to which they refer their patients. While there is no assurance of better quality in these arrangements, what is clearly shown is that the patient pays more, the system pays more, and the reasons for referrals are governed by profit and not by quality.

I would now like to share some of these comments from various regions of the country.

I would begin my summarization by reference to my own personal experience in Arlington, Va.

In recent years when I would go visit new physicians to discuss with them the referrals of their patients to our centers, there was a minute or two spent on the quality and equipment, and the remaining time is spent around the financial incentives available for the physicians. Can they get into joint ventures or other arrangements?

The existence of joint ventures and other financial arrangements has just about closed out the new markets.

My personal situation is repeated across the country.

From Austell, Ga., we have been advised of a private practice physical therapist who was forced to share, over a 4-year period, over $200,000 with referring physicians. When he called this activity into question as fee-splitting, the physicians formed a joint venture and his patient load dropped from 40 to 3 in a day. This therapist filed a lawsuit against the physicians as a last resort to survive.

Also in Georgia, another physical therapist—there was a joint venture arrangement set up between the hospitals and the doctors concerning physical therapy services, and that resulted in a third of that physical therapist's patients' leaving. And furthermore, he reported that many of these patients were currently in rehabilitation programs, and they were switched in the middle of their treatment.

From Los Angeles, we obtained a letter that was sent out by a physician on February 23, 1985, with an accompanying document which provides in part:

> I have become involved in a very important project that may be a help in protecting your future also. In spite of having my own physical therapy unit for years, at least half of my patients have been referred to physical therapy facilities out of my control. I have lost much potential income from these outside referrals. This is no longer necessary in my opinion. Through a network of physician-owned physical therapy clinics, five physical therapy centers in key locales will initially be set up, with 8 to 10 doctors participating in each one. Please open your mind to this potentially wonderful situation, which for no

and the no is underlined,

> extra effort or investment on your part, will have an additional source of income that is under your control and scrutiny.

Chairman STARK. Excuse me. Mr. Shauf, I have about 2½ minutes to make this vote, and my colleagues have not returned. If I can get you to suspend until Mr. Pickle or one of our members returns, I would appreciate it.

[Recess.]

Chairman PICKLE [presiding]. The committee will resume its sitting.

When the vote occurred, I believe that three of you had made your statement, and now we will hear from Lawrence Shauf. Have all three of the others made your statements?

Mr. Shauf, you are recognized now.

Mr. SHAUF. Yes. I am about half way through my statement.

Chairman PICKLE. You have not completed yours?

Mr. SHAUF. I have not completed it.

I was at the point of informing the committee of the letter that we received from a physician. It was a letter out to other physicians, and if I could quote:

> I have become involved in a very interesting project that may be a help in protecting your future also. In spite of having my own physical therapy unit for years, at least half of my patients have been referred to physical therapy facilities out of my control. I have lost much potential income from these outside referrals. This is no longer necessary in my opinion. Through a network of physician-owned physical therapy clinics, five physical therapy centers in key locales will initially be set up, with 8 to 10 doctors participating in each one. Please open your mind to this potentially wonderful situation, which for no

and the no is underlined,

> extra effort or investment on your part, will have an additional source of income that is under your control and scrutiny.

The document to the physicians goes on to provide the following:

> How do these developments affect the practicing physicians? These trends all point in the same direction—lost control of fees and revenues by the health professionals. Some realists have gone so far as to suggest that DRGs actually stands for "da revenue's gone." Physicians need to consider additional mechanisms by which they can maintain or increase their control over their own practices and services.

Many medical specialists suggest physical therapy for their patients, but few are able to control the revenues generated.

Our contacts in Sidney, Ohio, report that "almost every PT clinic in Cincinnati is owned partially by a physician group. In my office in Sidney," he reports, "physicians who are loyal to the hospital actually forbid patients to coming to my office, even though I have two master's degrees, and my fees are 50 percent of the hospital's" because of ownership arrangements.

Joint venture arrangements between hospitals and doctors are growing by leaps and bounds in the Chicago area, as the Chicago-based Baxter physical therapy has 17 such arrangements with hospitals and doctors.

In Gladsden, Ala., the following advertisement was sent to physicians by APRN—American Physical Rehabilitation Network:

> Physicians, you now have the opportunity to reach, with little or no investment, an equity position in a profitable joint venture. Our joint venture arrangement is just that—a genuine long-term relationship. You invest, we invest. You prosper, we prosper. APRN's new generation centers are the future, and the time to act is now.

In addition, we have received several reports from various other parts of the country, indicating magnitudes of physician-owned physical therapy centers, and I would like to share a few with you.

Other members of IPP in California have provided that in El Centro, Calif., with a population of 31,000, there are 3 physician-owned physical therapy centers; in Brawley, Calif., with a population of 19,000, there are 2 in Boise, Idaho 5; Midland, Tex., 4; Colorado Springs, 10; in Oklahoma City, 13.

Our network in Plainfield, N.J., provided us with data that in that area, of 41 physical therapy centers, 16 are physician owned. Tucson, Ariz., has three. San Pedro, Calif., has seven.

Our Massachusetts network provides us with the names and addresses of 30 physician-owned physical therapy centers, 20 of which are in and around Boston.

However, Mr. Chairman, not all is lost, because our network in Elmhurst, N.Y., reports that there are a number of private practice facilities, and they are doing well. However, our network contact has discussed this private practice situation with the physical therapists and they have been advised that successful physical therapists in the area have attributed their success to the giving of "consultation fees" to those referring physicians, and thus there are no joint ventures.

Physician ownership in physical therapy facilities is now almost the rule. Where do we go from here? How is the independent therapist to compete? And, most of all, is the patient being protected?

All the data we have received I will be happy to share with you and your staff for proper followup or further formal comment from our network members.

Mr. Chairman, I will be happy to answer any questions.

[The prepared statement follows:]

STATEMENT OF LARRY SHAUF, P.T., ON BEHALF OF THE INDEPENDENT PRIVATE PRACTITIONERS GROUP

Mr. Chairman, members of the Committee, my name is Larry Shauf, P.T., and I am in private practice as a physical therapist in Arlington, Virginia.

I am here today representing a group known as IPP Independent Private Practitioners in physical therapy. We formed this group 3 years ago and have members from throughout 46 states. The sole and only purpose of our group is to develop a network of private practice physical therapists who have no financial relationships with referring physicians. and who could be the source of data and information on the issue of physician ownership and other financial arrangements that threaten the existence of the independent practice of physical therapy.

Our aim is to provide this data to Federal, State and local health policy makers to demonstrate the extent of physician ownership in PT centers and the impact such ownership and other financial arrangements is having on the cost and quality of physical therapy services.

In the original legislation that this committee passed, there was a provision that would have prohibited physician ownership in physical therapy centers. In the final law, only prohibitions against ownership of clinical laboratories was enacted. We were advised that other areas of ownership were not kept in the statute because there was not enough data to support inclusion of PT centers and other areas where referring physicians have an ownership interest.

To combat this argument, that such data was not available and therefore to extend the prohibition to PT centers may not be appropriate, we formed the IPP to work with every group in PT, including the APTA to develop the data to demonstrate that the very same activity that led to the prohibition of clinical laboratory physician ownership, exists in physical therapy.

Mr. Chairman and members of the committee, I asked for the opportunity to present at this hearing so that I could report the findings of members of our network and hopefully demonstrate that the information that led to the prohibition in clinical laboratories is as significant, if not more so, in physical therapy.

Our data indicates that if the current trend of physician ownership continues, there may not be any private practice physical therapists. In every area of the country - - from Florida to Ohio to Chicago to Texas to California - - our network members have responded with examples of the magnitude of financial arrangements that physicians and hospitals have in PT centers to which they refer their patients.

In each of these responses there is a universal theme - - as a physical therapist I am charged with the responsibility to provide high quality physical therapy services - - I am trained and licensed to do so and nowhere is there a quality question. However, when the incentive to refer a patient to a physical therapy center is financial, by those who control the referrals, no matter the quality we give, we will get no patients.

In fact, while there is no assurance of better quality in these arrangements, what is clearly shown is that the patient pays more, the system pays more and the reasons for referral are governed by profit and not quality.

I would like to share some of the comments from the various regions of the country that we have received to support this contention.

I would begin my summarization by reference to my own personal experience in Arlington, Virginia. I have been in practice for 20 years and have developed my physician referral base because I provide the highest quality PT services. In years past, my discussions with my referring physicians always centered around my ability to deliver the highest quality service to their patients. In recent years when I go to visit with physicians to discuss with them the referral of their patients to our center, there is a minute or two spent on my quality and equipment and the remaining time is centered around the financial incentives available for the physicians - - can they get into a joint venture or other arrangement? Thus, in the last several years the only new patient referrals we have been able to obtain - - because we will not participate in a financial arrangement with a referring physician -

- is from the managed care environment. HMO's and PPO's have chosen us because of the high quality and the cost efficiency. They have no vested interest - - but as to new physician referrals - - the existence of the joint venture and other financial arrangements has just about closed out the new market.

My personal situation is repeated across the country.

From Macon, Georgia we have been advised that a private practice physical therapist was forced to share over a four year period $217,463.12 with his referring physicians. When he called this activity into question as fee splitting - - the physicians formed a joint venture and his patient load went from 40 to 3 a day. This therapist filed a lawsuit against these physicians as a last resort to survive. The same member of our network who advised of this activity reported that a joint venture arrangement was set up between a hospital and doctors concerning physical therapy services and that resulted in 1/3rd of his patients leaving and furthermore, he reported, many of these patients were currently in a rehabilitation program and they were switched in the middle of treatment.

From Los Angeles, we obtained a letter sent our by a physician on February 23, 1985, with an accompanying document which provides in part: "I have become involved in a very interesting project that may be a help in protecting your future also. In spite of having my own physical therapy unit for years, at least half of my patients have been referred to physical therapy facilities out of my control. I have lost much potential income from these outside referrals. This is no longer necessary in my opinion. Through a network of physician owned physical therapy clinics . . . five physical therapy centers in key locales will initially be set up with 8 to 10 doctors participating in each one . . . Please open your mind up to this potentially wonderful situation, which for no (and the no is underlined) extra effort or investment on your part, will have an additional source of income that is under your control and scrutiny. The document to the physicians goes on to provide as follows: "How do these developments (changes in reimbursement) affect the practicing physicians? These trends all pointing the same direction - - less control of fees and revenues by the health professionals. Some realists have gone so far as to suggest that DRG actually stands for "da revenues gone" physicians need to consider additional mechanisms by which they can maintain or increase their control over their own practice and the services . . . many medical specialists suggest physical therapy for their patients . . . but few are able to control . . . the revenues generated.

Our contacts in Sidney, Ohio report that "almost every PT clinic in Cincinnati is owned partially by a physician group". "In my office in Sidney," he reports, "physicians who are loyal to the hospital actually forbid patients from coming to my office, even though I have two masters degrees and my fees are 50% of the hospitals" because of the ownership arrangements.

Joint venture arrangement between hospital, and doctors are "growing by leaps and bounds in the Chicago area" as the Chicago based Baxter physical therapy has 17 such arrangements with hospitals and doctors. From Gadsden, Alabama the following advertisement was sent to physicians from APRN - American Physical Rehabilitation Network - - "Physicians you now have the opportunity to reach with, little or no investment, an equity position in a profitable joint venture" . . . "our joint venture arrangement is just that . . . a genuine long term relationship you invest - we invest - you prosper - we prosper - - APRN's new generation centers are the future and the time to act is now.

In addition, we have also received reports from various other parts of the country indicating the magnitude of physician owned physical therapy centers and I would like to share these with you.

Other members in California have provided data that in El Centro, CA with a population of 31,000 there are three physician owned physical therapy centers. In Brawley, CA with a population of 19,000 there are two physician owned centers.

In Boise, Idaho there are five physician owned PT facilities.

In Midland, Texas there are four physician owned PT centers.

In Colorado Springs there are 10 physical therapy centers that have financial ties with physicians.

In Oklahoma City 13 physician owned PT centers are operating.

Our network in Plainfield, N.J. provided us with data that in that area of the 41 physical therapy centers, 16 are physician owned.

Tuscon, Arizona has three physician owned facilities. One involves a pharmacist in a venture, another with Health South.

San Pedro, CA has seven off site physician owned PT clinics.

Our Mass network provides us with the names and address of 30 physician owned PT facilities, 20 of which are in and around Boston.

However, Mr. Chairman, not all is lost, because our network in Elmhurst, N.Y. reports that there are a number of private practice PT facilities and they are doing well, however, our network contact has discussed this private practice situation with the physical therapists and they have advised "the successful physical therapists in the area have attributed their success to the giving of "consultation fees" to their referring physicians and thus we have no joint venture.

Mr. Chairman and members of this committee, I have only reported some of the major findings of our network. In addition, we have FAX's from other areas of the country that include the cities yellow pages. Our network folks FAXed the yellow pages and noted those PT centers owned by physicians. These yellow page submissions hold consistent with the other data. Physician ownership of physician ownership of physical therapy facilities is now almost the rule - - where are we to go?

All the data we received, I will be most happy to share with you and your staff for proper follow up or further formal comment from our network members.

Mr. Chairman, I will be happy to answer any questions.

Chairman PICKLE. I thank you very much.

Now, Mr. Cooper, you were added as a part of this panel, and I assume that you have not testified or presented your testimony.

Mr. COOPER. I have not.

Chairman PICKLE. Then we would be pleased to hear from you now.

Mr. COOPER. I would be glad to.

STATEMENT OF MARK N. COOPER, PH.D., DIRECTOR OF RESEARCH, CONSUMER FEDERATION OF AMERICA

Mr. COOPER. Thank you, Mr. Chairman, members of the committee.

I have submitted three reports prepared by the Consumer Federation of America in the past few months, which deal, in general, with the perverse economic impact of physician profit from ordering of ancillary medical services.

Two of the reports deal with empirical evidence on the nature and extent of this abusive practice.

You have heard a great deal about that today, so I thought I would focus on the third report, which presents the results of a national random sample public opinion poll that CFA sponsored, asking a number of questions about these issues. We conducted a similar survey a couple of years ago when Congress was considering legislation dealing with this problem once before.

In this survey, we have sharpened our questions, to get at specific policy issues and concerns.

We find, actually, that the American people understand this problem well. They express a series of attitudes and preferences which are radically different than the current state of affairs in the industry.

First, they find it difficult to shop for ancillary medical services. The reason is clear; since physicians order them, and physicians read them, consumers cannot and do not shop. Only about one in six respondents to our survey said it was very easy to shop for ancillary medical services, which is in contrast to one-third who said it was easy to shop for doctors or hospitals, and one-half who found it easy to shop for prescription drugs.

It is quite clear that consumers care much more about the accuracy of their tests, and the competence of testing personnel, than they do about cost or convenience. Approximately 90 percent of respondents said that accuracy and competence of personnel were very important to them, compared to 54 percent who said cost was important, and only 39 percent who said the distance that they had to travel to take a test was very important.

Consumers are not willing to leave quality control to medical ethics—only 3 percent said that—or voluntary standards—only 15 percent said that.

They prefer a Federal standard—44 percent—to State standards—35 percent. I believe each of these issues has come up in earlier questioning.

They would like their physicians to stay out of the business of self-dealing. Only 15 percent said that physician ownership of ancillary medical facilities would be no concern to them. Forty-two percent said it would be a serious concern, and another 42 percent said it would be a small concern.

They would prefer to have laboratories bill directly for their work—77 percent—than have physicians include lab costs on their office visit bills—21 percent.

Schemes to control health care costs by paying physicians a lump sum, which has been an idea floated recently, and leaving the physicians to decide what to do with the testing, raised serious concerns. Although a majority feel that physicians would continue to order necessary tests, almost half of all respondents felt that physicians would either cut back on necessary tests, or avoid older and sicker patients who are likely to need more tests.

Public opinion clearly supports a major reform in physician self-dealing and markup for ancillary medical services, as does the empirical evidence reviewed in our other reports, and discussed earlier today.

Once these thorough reforms have been effectuated, reconsideration of Medicare fee schedules should be carried out.

Unless you undertake the major reforms first, you will be left with physicians who can dominate and distort the market by exercising their market power to further their financial interests.

The Federal decision to require direct billing for Medicare reflects a long record of documented problems. The Federal decision to outlaw physician self-referral for clinical tests reflects a long record and documentation of the problem.

But the real public interest solution to these problems lies, not in simply trying to save a few dollars for the Government, which will only create additional incentives to shift costs onto private payers and probably reinforce the movement to more abusive self-dealing practices. The real solutions lie in the thorough reform of the underlying marketing and billing in the entire industry.

The American people want their doctors to be doctors, not to be profit makers by selling them ancillary medical services.

Thank you.

[The prepared statement follows:]

Consumer Federation of America

TESTIMONY OF
DR. MARK N. COOPER
ON
PHYSICIAN OWNERSHIP AND REFERRAL ARRANGEMENTS

SUBOCMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

OCTOBER 17, 1991

Mr. Chairman and Members of the Committee,

Over the past decade the Consumer Federation of America has been actively involved in seeking reform of physician ownership and billing of ancillary medical services, such as laboratory tests, X-rays and other imaging services.[1] Our attention has focused on eliminating self-dealing and physician mark-ups of laboratory bills, as well as imposing rigorous quality controls on all testing services.

Physicians and some manufacturers of testing equipment have argued that banning the practice of self-dealing and imposing quality control would raise consumer costs or reduce the availability of services. In CFA's comments on the safe harbor regulations, we explicitly rejected these claims.

> For a number of reasons, we remain convinced that elimination of self-dealing can dramatically lower the nation's health care bills without jeopardizing the quality of health care. Because of improper incentives and ineffective regulation, lower quality labs and health service providers were not the lowest cost suppliers. The opposite has been the case.

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[1] "Testimony of Dr. Mark N. Cooper on Physician Self-Dealing and Quality Control in Clinical Laboratory Testing," before the Energy and Commerce Committee, United States House of Representatives, July 6, 1988; "Testimony of Dr. Mark N. Cooper on The Ethics in Patient Referrals Act of 1989 and Physician Self-Referral," before the Subcommittee on Health, Committee on Ways and Means, United States House of Representatives, March 2, 1989; Dr. Mark N. Cooper, "Comments of the Consumer Fedration of America," In the Matter of Medicare and Medicaid Programs: Fraud and Abuse OIG Anti-Kickback Provisions 42 CFR Part 1001, Department of Health and Human Service, March 24,1989; Statement of Dr. Mark N. Cooper on Cost Control of Medicare Part B Clinical Laboratory Tests," Energy and Commerce Committee, U. S. House of Representatives, June 8, 1989; Consumer Federation of America, Public Opinion About Health Care Purchases: Cost, Ease of Shopping and Availability (April, 1989); Consumer Federation of America, Self-dealing for Ancillary Medical Services: Potential Savings From Eliminating Overutilization (August 4, 1989).

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> Reform of ownership patterns and economic incentives will eliminate the incentive to overcharge and overprescribe. The bill for ancillary services will shrink and the number of procedures will decline, because the medically unnecessary procedures will diminish. There will be adequate providers available who are willing to supply services to the market in arms-length transactions.[1]

Our conclusions were based on a large body of evidence that had accumulated and been reviewed by CFA over a period of several years. Recently, the most extensive and explicit study of self-dealing confirmed our view. The Florida Health Care Cost Containment Board has found our conclusions to be right on point.[2]

CFA has continued its research and analysis into the problem of the perverse economic incentives created by physician profit making on ancillary medical services. We have recently completed three reports, which I submit for the record.

The first paper is entitled _A Consumer Perspective on Direct Billing_ and was released in July. It reviews the evidence on the abuse of mark-ups for laboratory tests which are ordered by physicians, sent out to laboratories, but included on the physician's bill, almost invariably with a very large mark-up. Medicare forbade this practice several years ago for the purposes of its payments, but until it is eliminated for all payors, there will be a gross distortion in the market for ancillary medical services.

The second paper entitled _Physician Self-Dealing for Diagnostic Tests in the 1980s: Defensive Medicine vs. Offensive Profits_ was released several weeks ago. It documents the rapid spread of physician ownership of ancillary medical facilities and the gross overutilization by self-dealing physicians. These practices were banned for clinical laboratories two years ago, but the regulations have not yet been fully implemented. That ban should be implemented aggressively and extended to all ancillary services.

The third paper, which we are releasing today, is entitled _Public Opinion About Quality, Self-dealing and Billing for Ancillary Medical Tests_. It contains the results of a national random sample public opinion poll about these matters. It shows, beyond a shadow of a doubt, that the American people support a thorough reform of these abusive billing practices. I will begin by briefly reviewing the results of the survey.

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1. Mark Cooper, _Comments..._, p. 27.

2. The Health Care Cost Containment Board and Department of Economics and the Department of Finance, Florida State University, _Joint Ventures Among Health Care Providers in Florida_ Volume II, August 1991, p. vi, reached the following conclusion:

Physician-owned, full service labs have significantly higher utilization rates, significantly higher revenue per patient and significantly higher operating income per patient than full service labs without physician owners. Nearly all of the objective indicators of quality reported by both lab groups indicate that nonjoint venture labs provide a higher quality product than their joint venture counterparts.

In sum, the findings reported here indicate that joint venture clinical labs perform more tests per patient, have higher charges per patient, and have significantly lower averages for objective indicators of quality of services than nonjoint venture clinical labs.

PUBLIC OPINION

The American people find ancillary medical service difficult to shop for. Only one out of six respondents to our survey said it was very easy to shop for ancillary medical services. This is in contrast to almost one-third who found it very easy to shop for doctors or hospitals and one-half who found it very easy to shop for prescription drugs.

They care much more about the accuracy of their medical tests and the competence of testing personnel than they do about cost or convenience of taking tests. Approximately 90 percent of the respondents said that accuracy and competence of testing personnel were very important to them, compared to 54 percent who said cost and 39 percent who said the distance they had to travel to take a test were very important.

They are not willing to leave quality control to medical ethics (3 percent) or voluntary standards (15 percent). They prefer federal standards (44 percent) to state standards (35 percent).

They want their physicians to stay out of the business of self-dealing for tests. Only 15 percent said that physician ownership of ancillary medical facilities would be no concern at all to them. Forty-two percent said it would be a serious concern and another 42 percent said it would be a small concern.

They would prefer to have laboratories bill directly for their work (77 percent), than have physician include lab costs on their office visit bill (21 percent).

Schemes to control health care costs by paying physicians a lump sum for laboratory tests and leaving the physician to decide what to do about testing raise serious concern. Although a majority feel the physician will continue ordering necessary tests, almost half of all respondents felt that physicians would either cut back on necessary tests or avoid older or sicker patients who were likely to need more testing.

THE FAILURE OF THE MARKET FOR ANCILLARY MEDICAL SERVICES

Our research makes it clear that this public concern about physician profit from ancillary medical services has a firm basis in the nature and structure of the market for those services.

A fundamental flaw on the demand side of the market underlies the ability of physicians to extract profits from testing. Patients are not the consumers of medical testing services, physicians are. Consumers lack the expertise to evaluate the necessity for or results of tests. When physicians self-deal for tests they appear on both sides of the transaction.

Even where physicians do not decide to engage in some form of self-provision of these services, there is an incentive to bill indirectly -- that is, to charge patients for services and then pay laboratories for the provision of service. Physicians can drive a wedge between the price they pay to the laboratory and the price they charge to the consumer, thereby increasing their own income. In other words, they have the leverage and can profit by extracting kickbacks from laboratories or by writing up their bills for these services to consumers.

Thus, physicians control the flow of demand for laboratory tests. The control over the flow of patients combines with fierce competition between laboratories and a wide range of options for physicians to give them the upper hand in the bargaining with the laboratory. Because the physician can go to another lab, set up an in-office lab or own an outside facility to get the services (and the laboratory cannot compete directly for the physician's patients), the labs lose out to physicians. the physician can always threaten to self-supply.

Under current law, physicians have used their control over the ordering of tests to extract discounts on non-Medicare tests. If the laboratory does not agree to lower its charge on tests billed to private parties, physicians take their business elsewhere. The lower price the physician extracts for privately-billed tests is then marked-up by the physician. Large volume physicians can play labs off against each other to achieve the highest discount and then reap the largest mark-ups.

Medicare ends up paying more, when the laboratories make up for their losses on private tests by shifting costs to Medicare. The private sector also ends up paying more because of the mark-up by high volume physicians and because labs shift costs onto privately billed tests of lower volume physicians.

EMPIRICAL EVIDENCE OF ABUSE

The empirical record of abuse of ancillary medical service referrals and billing is quite extensive. Our analysis shows that the most significant change in physician practices in the 1980s was the dramatic increase in financial arrangements between physicians and facilities providing ancillary medical services

Almost unheard of a decade ago, physician ownership and compensation arrangements with these facilities have grown to the point where recent studies suggest that one-fifth or more of all physicians may be involved. Including significant physician office lab testing, the self-dealing rises to as high as fifty percent.

For clinical laboratories, which provide the bulk of diagnostic testing, physician ownership appears to be in the range of one-third to one-half. In some specialties like the rapidly expanding field of Magnetic Imaging Centers, physician ownership exceeds fifty percent.

The impact of self-dealing is not surprising. When physicians have a profit incentive in a testing lab, the number of tests they order and the total bills they generate are higher. For clinical labs, recent studies show the following.

(1) Compared to tests ordered at independent labs, self-dealing physicians ordered 34 to 96 percent more tests.

(2) Prices were 2 to 38 percent higher.

(3) The total bill was 26 to 125 percent higher.

Moreover, recent studies show that these findings also apply to diagnostic imaging services and compensation arrangements.

The motivation for physician ownership is simple and direct -- economic profit. The professional literature describing self-dealing assumes rates of profits on the order of fifty percent per year or more and assures physicians that locking in their patient base through self-referral guarantees success. The rates of profit identified in the self-dealing and mark-up literatures are astounding. Many of the prospectuses and analyses in the professional literature assume payback periods of one year. Mark-ups, when they have been looked at, have been in the neighborhood of fifty to one-hundred percent. The academic literature on physician behavior leaves no doubt that utilization of services is highly responsive to these economic incentives.

PUBLIC POLICY IMPLICATIONS

The obvious public policy conclusion that emerges from these detailed analyses is that a thorough reform of the perverse economic incentives in physician ownership and mark-up of ancillary medical services is necessary. Once this has been accomplished, reconsideration of Medicare fee schedules should be carried out. Unless these practices are restricted, the physician will dominate and distort market performance by exercising his market power to further his financial interests.

The federal decision to require direct billing for Medicare reflects a long record of documented problems, but abuses continue for non-Medicare business and the potential linkage between Medicare and non-Medicare business continues to give physicians immense leverage to extract profits on private business.

Therefore, the real public interest solution is not simply to try to save the government a few bucks, which will only further the incentive to shift costs onto private payers and probably reinforce the movement to more abusive self-dealing practices. The correct solution is to reform the underlying market and billing structure in its entirety.

Any talk of reform of the medical profession, whether from the point of view of physician practices, laboratory profits, or total cost, must start with the fundamental economic structure of the industry.

Chairman STARK [presiding]. Thank you.

I have one particular question, and I guess a statement, in regard to Dr. Miller's testimony.

As I understand the issue of lithotripsy, it does not technically fall within the bounds or guidelines even of the 1976 law—and if I can explain that just for a moment.

That is not to say it does not raise a very interesting issue, but the law in 1976 refers to "referrals," and fee-splitting for referral. And I have often used the illustration of a general practitioner, a sole practitioner in a small town, who may very well own an x ray machine, and not necessarily be a radiologist, but, legally capable of operating that machine, and supervising an x ray technician, maybe not to the same extent that a board certified radiologist might.

But, there is nothing illegal in the Medicare laws about that. Nor is it illegal for an internist to own and operate an electrocardiogram machine in his or her office. So, all of those issues where somebody owns the machine directly, participates in its operation both financially and professionally, are outside the law.

Now, the issue I believe Dr. Miller is getting at sounds to me more like a concern of possible restraint of trade, which is not necessarily the topic here today, although certainly of interest to this committee.

What I am hearing, and I am confused by, is that there is a range of charges for lithotripsy, and indeed a range of complication—I hate to say apples and oranges, but I gather the size of the stone and the severity of the case makes a difference.

But what does trouble me is that Medicare, I believe, pays—and to try and put all of this as apples—around $3,200 for what I would refer to as a "bundled" procedure—the doctor's fee, the use of the machine, the whole magilla.

And some of the discussions we have heard today refer to just the machine, or just the physician's fee, and it is hard to compare that unless you lump it all together.

I have further been advised by Georgetown that the price for a procedure here in the District of Columbia today could run from $7,000 to $9,000. Medicare, mind you, would pay about $3,200, $3,250.

It is, I think Dr. Miller has suggested, $7,000 or $8,000 in Memphis. I am advised that Southern Cal Edison, who we have all felt has one of the most aggressive and effective cost control preferred provider operations in the United States, is able to negotiate rates in the Los Angeles area, arguably the highest cost medical area in the country, in the neighborhood of $4,200 to $5,200. And there is a major difference there.

I hate to refer to Click and Clack, the Tapit Bros., but we are all familiar with mechanics doing their own callbacks. You get the car tuned up and it still misses, the mechanic has to do the second tuneup free.

Well, Southern Cal Edison has negotiated their rate so that if you have to go back, which I understand is not uncommon, for a second or third shot of whatever happens to you in this tank, it is done at no additional cost to Southern Cal Edison. In other words, if they do not get it right the first time, they do it a second time until it is done, which is not the case, I understand, in Memphis.

Now, this calls attention to the fact that Medicare has found that the Federal Government should be paying about $3,200 for a procedure, which in other areas runs as high as $9,200. This is a matter of concern to the committee, and to the Government. Either we are woefully and grossly underpaying under Medicare, or some of our constituents are paying higher insurance premiums, generally, to cover these higher $9,200 costs.

Unfortunately, it is difficult to find anything illegal in this, but it is certainly something that we should take under consideration, I believe, as we look at overall cost containment. And because the question of restraint of trade would not necessarily be before this committee, I do not know that it is an issue that we can technically take up.

I did not want to just ignore your excellent testimony, Dr. Miller, but I thought—it is a concern. It is not, however, technically, at least in the Chair's opinion, something that would be dealt with by this—in other words, even if we passed the strictest antireferral bill, these groups would not be covered by it. It is something else that we should take under advisement, and I assure you we will.

I would like to look into this further, and I know HCFA, which I—I did not want to dismiss your testimony, but I wanted to separate it a little bit from the other issues that we are considering in this morning's hearing.

With that, I would like to recognize Mr. Ford.

Mr. Ford. Mr. Chairman, let me welcome Dr. Miller to the committee, from my hometown, Memphis. We are very proud to have you before the committee.

There are several questions I want to take up, where the chairman of the committee left off.

Dr. Miller, could you explain to the committee what a normal lithotripsy procedure involves?

Ms. Miller. First of all, I am not a physician, but I will try as best as I understand it.

There have been basically two types of lithotripsy. Both of them involve the use of shock waves to destroy the kidney stones. The older machine that was owned by the hospital did require hospitalization and anesthesia. One of the arguments used by the group of urologists, which is virtually every urologist in Memphis qualified to do the procedure, is that the newer machine is more efficient, more modern. We are not arguing that point. I think that probably it is, even though there are questions regarding whether or not the patient has to be hospitalized for pain or their complications. When these occur, regardless of the machine, they are probably going to be admitted.

Our concern has more to do with the charges, both from an employer's perspective, a patient's perspective, with the restriction of choice on the patient's part, and potential conflict of interest.

Mr. **Ford**. All right, there have been several articles in the major newspaper in Memphis, and I think that one even appeared this morning. But can you explain which procedures are included, maybe, in the $7,100 charge by the lithotripsy organization?

Ms. **Miller**. From what I understand, the $7,100 includes anything associated with the actual zapping of the stone, which is really, essentially what happens. It does not include the $2,000 for the urologist fee.

Now, from what I understand, it is very hard to compare what the old charge was, and make it an apples-to-apples comparison, mainly because with the old charge there may have been a hospitalization of a day or two, with anesthesiologist charges, and often be billed under one normal inclusive charge.

Mr. **Ford**. These procedures would be considered as usual and customary, is that it?

Ms. **Miller**. The procedure or the doctor? No.

Mr. **Ford**. Yes. For the $7,100 fee. You are saying, billing separately, but——

Ms. **Miller**. The $7,100 is not subjected to "usual and customary," because that is an equipment. Only physicians charges are subjected to "usual and customary," not facilities or equipment.

Mr. **Ford**. I know when one of the newspaper articles appeared in our newspaper, in talking with Blue Cross/Blue Shield, and some of the other health organizations, they indicated that these procedures were considered usual and customary, that falls within the $7,100 fee.

Ms. **Miller**. Only physicians charges are under a usual and customary fee. There is some confusion on that. Only procedure codes under physician's charges would even be under a usual and customary. They may be referring to the fact that that may be a typical community rate, but it was not prior to this machine coming into town. And according to some of the other examples, it is still higher than what you should expect for our community.

Mr. **Ford**. Well, can you explain to the committee the procedures under the $1,100 fee of the new machines?

Ms. **Miller**. OK. I did not bring that up before the group, but it was in my written statement. I really do not know. We had a proposal from a company in California who offered to bring a machine that they said was similar, for $1,100 per treatment, which we would prefer over the $7,100 per treatment.

However, you must have a physician—a urologist—who is willing to perform the procedure, and from what I understand, they have signed a no-compete contract, which says that they will not use any other machine, other than the one that they own.

So, all the machines in the world—$1,100 or whatever—would not do us any good.

Mr. **Ford**. My time might be expiring, but I know that the same treatment, and the same machine—and I think the chairman might have touched upon it—out in California, and in Minnesota has been used. The total per treatment charges exceeded the $7,100 in many instances. You can correct me if I am wrong.

Ms. **Miller**. OK. The proposal that we got was for $1,100 per treatment.

Mr. **Ford**. That is only for the use, the rental, of the machine alone, is it not?

Ms. **Miller**. Yes, but it is an out-patient, nonhospitalized treatment, which is the same as the one that the Lithotripsers, Inc., people have.

You realize that this $9,100 for this treatment is for a 1-hour out-patient charge.

Mr. **Ford**. Right.

Ms. **Miller**. It is 1 hour.

Mr. **Ford**. And this $7,100 fee is a global fee.

Ms. **Miller**. The $7,100, plus $2,000 for the urologist, is global for the 1 hour out-patient procedure—yes.

Mr. **Ford**. And the other per treatment is a la carte.

Ms. **Miller**. That was not the proposal as I read it. I think maybe for the $1,100, there may be some things that were not listed on that. Really, right now—I sent it over to be reviewed by one of the hospitals.

Mr. **Ford**. Well, reducing any of the costs is a priority for me. I just wanted to make sure, after reading the articles in our local newspaper——

Ms. **Miller**. It has been very controversial. It has stirred up a little hostility in the community, needless to say. And we are trying to do an apples-to-apples comparison, as best we can.

I received the invitation to come here last week, and it was a little late to be able to pull very many bills to look at them.

Mr. **Ford**. Well, I really thank you for appearing before the committee.

Ms. **Miller**. Thank you.

Mr. **Ford**. Mr. Chairman, I yield back the balance of my time.

Chairman **Pickle** [presiding]. Thank you, Mr. Ford.

Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman. Sorry about the others on the panel, but I want to address my question to Dr. Miller, too, because this is an intriguing situation.

I am especially interested in knowing what the Memphis Business Group on Health, itself, is doing about this. In particular, has your group, as a group, been involved in attempting to bring an antitrust action, or participate in an antitrust action, or provide information, or file a complaint with the Justice Department, which might lead to an antitrust action?

Ms. **Miller**. We have had some conversation with both the Justice Department and with the Federal Trade Commission.

I have been contacted on several occasions, have had phone calls, and answered their direct questions. We have not brought any kind of charges ourselves against anyone. But we are certainly cooperating with the investigation, or the evaluation, at this point, of what is going on.

Mr. Gradison. Did you initiate these contacts, as an organization, with the Justice Department or the Federal Trade Commission, or were you responding to an inquiry from them?

Ms. Miller. I do not think I initiated it. I sent a copy of an article that came out in the local newspaper to the Washington Business Group here, and asked them to respond to it, and I think it was probably during the course of passing of information that this happened.

I did not call them, but when they called me I certainly supported their efforts in looking into it.

Mr. Gradison. Only one other related question—has the Memphis Business Group on Health at any point considered hiring a urologist from outside the community and bringing them in to take care of the patients of these companies, as a means of having a little more control over the situation?

Ms. Miller. Yes. We have considered it.

Mr. Gradison. But not yet——

Ms. Miller. We talked about it. We have not pursued it.

Let me tell you why. I represent very large employers. We have 100,000 covered lives in Memphis, and about 90,000 outside of Memphis. We probably could get some pricing concessions. There have already been some indications of willingness to talk to us about that because of how big we are. We may have to do that, because the $7,100 is just a tremendous hit.

But, I feel that at this point it is selling the community out. That if, indeed, the big guys take a cut, be it to $5,000 or $4,000, the rest of the citizens in Memphis, who are not represented by this arm, will have to pay the higher price. And in a community that has already been hit hard with health care costs—we have a very high number of indigent patients—at this point, I do not want to desert the community.

You know, I am here today as another way of trying to address the problem.

Mr. Gradison. I understand exactly what you are saying. I certainly respect the community-wide concerns which your comments just expressed.

I have to just tell you what runs through my mind, as you said that, is that on that basis, why would your group even want to negotiate managed care contracts of any kind. Because the argument could always be made that an effective managed care arrangement on the part of the major buyers runs the risk of shifting costs to others.

Ms. Miller. It does. We are all aware of this, and I think that a lot of the managed care efforts that we have done have been crisis intervention. "Let's do this," and as soon as we get it started, let us look at it from the community perspective. What can we do to try to help change the system.

And Memphis is doing that. We are just now ready. We did our crisis management, and now we are trying to look at what can we do to try to stop some of the cost shifting, which I think is happening.

I am a small employer—the Business Group is—even though we have huge clients. I had a 72-percent increase in my insurance premiums for staff this year, which was probably typical of very small employers, but it was a real slap in the face when you look at what we do for a living.

Mr. GRADISON. Yes, it brings the message home, that is for sure.

Ms. MILLER. Yes.

Mr. GRADISON. Thank you very much, Mr. Chairman.

Mr. FORD. Mr. Chairman, can I be recognized for 30 seconds?

Chairman PICKLE. Go ahead, I will yield.

Mr. FORD. I wanted to just pick up where Mr. Gradison left off. I certainly can understand the position of Dr. Miller, here, and at the same time, Medstone. I am also aware of the situation in California and Minnesota. Since the episode covers all of the components of this care, we do not want to impose a higher charge than the $7,100.

Dr. Miller, you said earlier that you would like to rent this machine for $1,100. When we take in all of the components, like we have seen in other parts of the country, I am still uncertain what the actual care costs will be in the Medstone—costs other than the $1,100 for the rental of the equipment itself.

Ms. MILLER. Is that a question?

Mr. FORD. It was not a question, it was just a comment.

Ms. MILLER. Well, the thing with Medstone has never been pursued. Medstone is a piece of equipment for which we received a proposal from, out of California, and, again, I sent it to the hospital. I am looking more at comparing the $7,100 against the old machine, use of the machine, of $3,300 to $3,600 range of what we probably were paying prior.

The Medstone thing has really never been pursued because of the fact that we could not evaluate exactly what it was they were offering.

Mr. FORD. But I do not want to get a global fee confused with the mere rental of the machine. There is a big difference in $1,100 and $7,100. And we have seen, with other charges, the cost of the Medstone or whatever, increases from $7,500 to $9,500 if you look at it as a global fee.

Ms. MILLER. Our data has not really shown that. It probably is within—just trying to do apples-to-apples—it probably is within the $3,300 to $3,600 range as compared to the $7,100, exclusive of the $2,000.

Mr. FORD. But, you do not have any procedural breakdowns as to what brings it up from the $3,300 to $3,600. It is just a guesstimation; is that correct?

Ms. MILLER. Yes, it is very difficult, because in the past it was billed and may include hospitalization charges for overnight, or 2 days. So it is very difficult because of the billing practice, of seeing the comparison.

So what I did was call the hospital who is part owner of the machine, and said, "Give me an apples-to-apples comparison, that I am real comfortable with saying that probably the $3,300 to $3,600 range would be comparable to $7,100."

So, if we cannot have the $1,100, at least give us back the $3,300 to $3,600.

Mr. FORD. Right, and what happens with the Medstone if the first care does not break up the stones, what is the charge for the second time around?

Ms. Miller. Again, we have not really pursued the Medstone. We have been working with the area hospital, but from what I understand in their proposal is that any followup within a predefined time, like the Lithotripsers, Inc., would be done a second time without additional charges.

Mr. Ford. OK. Thank you, Mr. Chairman.

Chairman Pickle. Dr. Miller, or any of the panel, there seems to be quite a spread about costs on these lithotripsy machines. One is at $3,400, the one the physician owned is $7,100, and another group has offered to bring them in for much cheaper.

So, it seems to me our problem is one about cost. It is not one of overutilization, is it?

I will ask you, Dr. Miller, with these machines is it a matter of overutilization? Is that our problem?

Ms. Miller. In our case, it is too early to tell, because this just happened in May.

I went into our data base to look to see, and from my companies who I was representing, we did not have any in Memphis for 3 months prior to the machine coming in. We had eight in the next 3 months. It may be too soon. If that is an indication, we are in trouble.

Chairman Pickle. Well, from the statements that most of you made, I do not get the impression that our problem is one of overutilization with respect to these machines—these kidney machines. That could be done, but that would be very difficult, any more than you cannot overutilize in chemotherapy. That is almost a fact.

Now, our problem, then, is one of cost. And the assumption is if the machines are owned by physicians, that automatically is going to be a much higher cost than anybody else's. Now, that may or may not be true.

Let us suppose that we take that first step. What guarantee can you give me that the cost would not be the same, or would be very low, if the machines were owned by nonphysicians?

Mr. Cooper. Well, the only guarantee that one can give is that you would have real competition. That is, you would not face the prospect of having anyone who is looking at the community being faced with an iron-clad contract that says, "You cannot get patients."

So, the presumption is that if you did not have locked up self-referral, or self-dealing, you would get competition.

Chairman Pickle. That might be true if there is one machine in the world, or one machine in the city. There are going to be more and more and more of these machines, and there is going to be competition, whether they are owned by the physicians or whether they are owned by groups of nonphysicians.

Mr. Cooper. Well——

Chairman Pickle. So that is going to be inevitable. Most of the time when you get a new machine that is different, and nobody else has got it, the cost seems to go way up, and it comes way down when you get the competition.

And I am just saying to you, I do not know that you are automatically going to have a much cheaper price when it is owned by nonphysicians.

Now, you seem to think, or some of you seem to think, that the physician ownership is a problem. Mr. Schwade.

Dr. SCHWADE. Yes. Now, with radiation therapy we are talking about a different situation. We are talking about extremely expensive pieces of equipment which, if they are bought by self-referral groups of physicians, results in instances such as in Dade County, Fla., where I practice, where you can have hospitals where there already existing units, costing upward of $3 to $4 million, and a group of self-referral physicians creates a situation where you have twice as much equipment being utilized by the same number of patients and that is a cost that is borne by the community that is actually higher.

And there is also tremendous potential for overutilization of treatment of cancer patients.

Chairman PICKLE. All right. Let me ask you about that. Your testimony states that there is, "a tremendous potential for overutilization of radiation therapy when physicians refer their cases to a radiation center."

Now, the Florida study that we heard early this morning found no overutilization in the case of physician-owned radiation therapy centers.

So, I ask you then, what evidence of overutilization are you aware of?

Dr. SCHWADE. Well, I can give you a number of examples in Dade County, Fla.

Chairman PICKLE. All right. Give them to me.

Dr. SCHWADE. The first one is the one I am most familiar with, which involved Baptist Hospital of Miami, which had a——

Chairman PICKLE. Which hospital?

Dr. SCHWADE. Baptist Hospital of Miami, which had a very fine physical plant, and as the population of cancer patients from south Dade County expanded, the neighboring hospital—South Miami—also got a certificate of need from the State to build a radiation oncology department.

But despite that, a group of 80 to 100 of the largest users of both those hospitals was organized by one of the surgeons in the hospital, to create a unit which was located several miles from either of those hospitals, and the condition today is that you now have seven linear accelerators—which, depending on the energy can run from $500,000 to $1.5 or $2 million each—in a community that could probably be well-served with three or four. Now, that is a cost that has to be borne by that community.

In South Broward County, which is just neighboring Miami, in the Ft. Lauderdale area, at Hollywood Memorial Hospital, actually slightly earlier than the Baptist example, a similar incident took place, where the largest referrers to the cancer services at that hospital also put up a radiation therapy unit which eventually forced the hospital to have to buy the second unit, and the hospital now operates two units, where one would have been sufficient before.

Chairman PICKLE. Well, you are not charging that a physician is prescribing extra or excessive treatments of radiation, are you?

Dr. SCHWADE. What I am saying is that these type of self-referral situations create a situation where an entity can become economically feasible where otherwise it would not be economically feasible. That is a form of overutilization that increases the cost to the community.

Chairman Pickle. Well, you are not saying that the physician can recommend an additional radiation treatment that would not necessarily be required.

Dr. Schwade. There is a tremendous——

Chairman Pickle. You are just saying there is a tendency for them to recommend more utilization of radiation treatment——

Dr. Schwade. Well, I have seen that happen. I have seen situations where physicians are in a position to make a decision about whether a patient with a marginal is referred or not referred, and they referred to those types of units.

Chairman Pickle. I would like for you to give this committee, if you can, which hospital in Miami and which physician might have made repeated prescriptions for unnecessary radiation treatment.

If you would let us have that information, we would like to look into it. If you have any specific cases of overutilization, I think this committee would like to know it.

Dr. Schwade. I cannot give you a specific name of a specific patient who was referred by a specific doctor.

Chairman Pickle. Or the physician who is overprescribing. Can you do that?

Dr. Schwade. A specific physician who is overprescribing?

Chairman Pickle. Can you give us the name of any physician who is actually saying to a patient, "We are going to send you for radiation treatment," when they do not really need radiation treatment, or they are going to give you 10 radiation treatments when they only need 1.

Can you give us evidence of some abuse in these areas?

Dr. Schwade. Well, I cannot give you the name of a specific—at this time—a specific physician who is abusing with this type of a referral pattern.

Chairman Pickle. Well——

Dr. Schwade. But, I think——

Chairman Pickle. If you can give it later, we would like to have it.

Dr. Schwade. If I could make a comment about the Florida study, Congressman, which you brought up.

The Florida study identified, I think, if I recall, approximately 31 freestanding radiation therapy centers which they sent questionnaires to. Twenty-three of those responded.

Part of the problem was that of those 23, 10 were actually owned by physicians, and the remainder were joint ventures.

Their conclusion was not that there was not abuse, but that they did not have enough data to make a conclusion.

Chairman Pickle. That may be a factor, and that is common to all of our surveys, though.

Dr. Schwade. Well, it was a small number of respondents. But, if I could emphasize the problem that we are dealing with are not entities that are owned by physicians. I feel very strongly that a practicing physician has a right to own the facility in which he practices.

We are talking about situations where physicians are in a position to refer patients to one entity or another. It is anticompetitive.

Chairman PICKLE. I see your point on that.

Mr. Shauf, you said right toward the last of you testimony that the physical therapy facilities in your great—that is in New York—have no competition from physician-owned facilities because they pay "consultation fees" to referring physicians.

Now, I want you to describe to me what kind of fees, what kind of "consultation fees," and what was the amount of these fees?

What is the difference between these fees and a kickback?

Mr. SHAUF. I do not believe there is any difference between those. The situation is one in which there was a physical therapist who started out his own practice in a community where physical therapy seemed to be—particularly in private practice—seemed to be doing quite well.

After a short period of time, this gentleman was not able to get his practice off the ground, if you will, and made a consultation with one of the other physical therapy groups that seemed to be doing quite well, to inquire as to what he was doing wrong.

And he was told that what he was doing wrong was that he was not playing the game. He was not providing fees back to the physicians.

In what form these fees took place, I am not really sure, and I would be more than happy to work with this member of our association to get you that data, however.

Chairman PICKLE. This committee would like to be sure of those kind of charges, because if they are "being required to pay consultation fees," that is mighty close to kickbacks, unless there is some other way to explain it.

I would like for you to give us any information in that respect that you have.

So, I am going to ask the staff to be in touch with you as a followthrough, and we will see what we can find out about that.

Mr. SHAUF. Yes.

Chairman PICKLE. Now, Mr. Cooper, your testimony indicated that physicians order more services when they invest in ancillary medical facilities. But your discussion seemed to be limited to clinical labs. Am I correct on that?

Mr. COOPER. Well, the predominant evidence over the past decade has been with clinical labs, but you are now getting mounting evidence of overutilization in MRI and physical therapy as well.

Chairman PICKLE. Well then, you are saying that in addition to prohibiting doctors from referring Medicare patients to a clinical lab, that we probably ought to have the same kind of limitation with respect to MRIs or physical therapy and all the other treatments. Is that correct?

Mr. COOPER. It is our belief that when you get enough data and the opportunity to study it, you are going to find the same pattern of abuse, within certain limits set by physician practice.

But clearly, MRI and physical therapy have started to generate the same sort of clear evidence on patterns of abuse.

Chairman PICKLE. Well, we have another panel yet to be heard from today, so I do not think we will continue.

We may be submitting to some of you individuals some questions for further response. But I would also say to you, when we are asking for some of these "charges," give us the facts and some information on it, and we will try to follow through to see if that is taking place.

Thank you very much.

Now, the Chair would ask the last panel, consisting of Thomas Mills and Hal Mardis if they will please come forward.

Thomas Mills is counsel of Radiation Care, Inc., from Atlanta, Ga. Where is Mr. Mills?

Mr. MILLS. I am here, sir.

Chairman PICKLE. Do you have some individual with you?

Mr. MILLS. I do, sir. I have with me Dr. Edward Hughes, who is vice president of medical affairs for Radiation Care, sitting at my left, your right, sir.

Chairman PICKLE. From Atlanta?

Mr. MILLS. Yes, sir.

Chairman PICKLE. All right.

Then Hal Mardis is the past president of the American Lithotripsy Society, from Omaha, Nebr.

Mr. Mills, if you will proceed first. And I would ask both of you—we have legislation on the floor, and we are anticipating another vote—if you would summarize your testimony for approximately a 5-minute period, we would appreciate that.

Mr. MILLS. I would be glad to do that, sir.

STATEMENT OF THOMAS L. MILLS, COUNSEL, RADIATION CARE, INC., ATLANTA, GA., ACCOMPANIED BY EDWARD N. HUGHES, M.D., PH.D., VICE PRESIDENT, MEDICAL AFFAIRS

Mr. MILLS. Mr. Chairman, my purpose here is to give a little definition to the debate that we have heard earlier on.

We support most of the groundwork that was laid here by you, and by Chairman Stark, Mr. Schulze, and Mr. Gradison, about how these things ought to be looked at—what the proper role of the Government is in looking to see if there is abuse or not.

And we would urge, therefore, a very clinical look at what is and is not alleged, what is and is not possible, what is and is not proven. And we think that the Florida study, for all of its many faults, nevertheless is an enormous addition to the learning on the subject, and we think it is very valuable.

What we would urge, Mr. Chairman, is an analytical basis for looking at the issue of physician self-referral. What kind of abuse can occur?

Overutilization is the prime evil. There is some evidence of overpricing, because of the alleged hold on a patient that a physician has. There is also alleged generally mistreatment of patients.

Now, looking at it from that kind of a framework, the empirical results from the Florida study are not surprising. In a situation where a physician refers lab tests to a clinical laboratory, it is possible for the physician's financial interest to cloud his therapeutic judgment. You can order five lab tests or six lab tests, and it is very hard to weed out whether it is proper—whether it is therapeutically or financially indicated.

It is possible to order more x rays rather than fewer. It is possible to send a patient for physical therapy for a longer period, rather than shorter, because in each case the physician's discretion is indicated. It is not practically possible to subject a patient to lithotripsy who does not have a kidney stone show up in the crosshairs of the machine. Nobody is being subjected to chemotherapy, or radiation therapy, who does not have the medical indication. I do not know of any case where a patient is being subjected to kidney dialysis, who does not have end-stage renal disease.

And so, in those cases, the overutilization argument is simply nonexistent, and if there is overpricing, then the overpricing ought to be looked at on an economic model. Is there a basis for it? Is there an alternative facility? What would the situation, the economic environment be, in the absence of the existing facilities.

I think that we can see from Florida, itself, with the tremendous extent of physician investment there, what would the climate and the environment be for treatment were you to wipe that physician investment out right now?

So, one fault I have with the Florida study is there is no chronological look at when and how and why physicians got involved in their investment. And is there a basis to conclude that, but for the physician investment, there would not be the facility that is needed?

I have a lithotripsy client in Florida who tried in 1986, 1987, and 1988 to get the hospitals in northwest Florida to purchase a lithotripsy machine. All of the urologists tried for 2 years to get the hospital to purchase a machine. The hospital did not purchase a machine. Their patients either had to go to Gainesville, a couple of hours away, or they were subjected to open surgery.

The cost in Gainesville, at the University of Florida, was about $11,000 per procedure. The cost of surgery is approximately the same, involves about 2 weeks in the hospital, and 6 to 8 weeks recovery time.

The physicians all got together, bought the machine, set up the facility, and from day one the facility has been chock-a-block. The cost of the procedure was cut in half. So, but for that physician investment, the patient population in northwest Florida would be tremendously disserved.

This is an example. And I have heard other examples, on the other side of this debate, today, which are compelling. That is to say that physician-ownership is always right, but it is certainly not always wrong. If you will use the analytical basis which the empirical data in the Florida study presents, and logic, and the natural constraints of medical practice, I think it gives us a good handle on where to look and where not to look.

Now, let me look at radiation therapy, itself, and I want to take specific issue with the witness on the previous panel. It is true, Mr. Chairman, that only about 40 percent of patients with cancer are properly subjected to radiation therapy, as opposed to surgery or chemotherapy, or a combination of all of those.

But the medical indications and the constraints on the system are such that it is inconceivable to me that anyone is being subjected to radiation therapy who is not indicated for that under good medical practice.

And I was glad to see the chair ask the question, and ask the witness to submit the data, because in radiation therapy, if there is a doctor who is treating a patient who does not need it, it is the radiation oncologist who is doing that, not the referring doctor. There is a very, very sharp difference, here, between referring doctors, as a general rule, and treating doctors.

A referring doctor in a clinical laboratory situation orders the test and it is done. A referring doctor in a diagnostic radiology situation orders an x ray or a CT scan and it is done.

A referring doctor in radiation therapy sends his patient to the radiation oncologist, who alone decides whether or not the procedure is to be done and, if so, the whole treatment regimen.

So if the witness, in fact, were aware of an abuse—of a particular abuse in radiation therapy—it would not have been an abuse borne of the referring doctor, but of the radiation therapist.

And no less friend of physician joint-ventures—and I say that with a smile—than the Inspector General of the United States regards hospitals and treating doctors in the same category of "interested investor," as he does "referring doctors." It is easy to see that a radiation therapist who practices at a hospital would be under the same constraints from the hospital as he would be from medical oncologists, urologists, and pulmonologists who might own the facility.

I reject, categorically, the notion of abuse in radiation therapy. It is practically impossible, and if there is any abuse, it is on the part of the radiation oncologist, whom the witness defends completely as having the right to own the facility.

It is clear to say that if a radiation oncologist owned the whole of the facility, his financial incentive would be massively more than if he coowns it with referring doctors, since he is, in that case, the gatekeeper.

That completes my oral presentation.

[The prepared statement follows:]

TESTIMONY OF THOMAS L. MILLS
ON BEHALF OF RADIATION CARE, INC.

My name is Thomas Mills. I am a principal in the Washington D.C. law firm of Dyer, Ellis, Joseph & Mills. I am here today on behalf of Radiation Care, Inc., which provides outpatient radiation therapy services utilized in the treatment of cancer. As you know, I also represent a number of national and local physician-owned providers of therapeutic treatments, including T² Medical, Inc. I will be pleased to answer questions concerning any of these therapies. Thank you for the opportunity to speak today.

With me is Edward N. Hughes, M.D., Ph.D., a radiation oncologist and Radiation Care's Vice President for Medical Affairs. Prior to joining Radiation Care, Dr. Hughes was an Assistant Professor in the Department of Radiation Oncology at the University of Pennsylvania School of Medicine and was on the staff of the Department of Radiation Oncology at the Hospital of The University of Pennsylvania. During 1987 and 1988, Dr. Hughes was chief resident in radiation oncology at the Joint Center for Radiation Therapy at Harvard Medical School. Dr. Hughes received an M.D., Ph.D. degree from Johns Hopkins, and is a member of a number of societies. He is board certified in both Pediatrics and Radiation Oncology. Dr. Hughes will answer any medical questions you may have.

Radiation Therapy

Radiation therapy, which treats cancer with high-energy radiation, is used alone and in conjunction with surgery, chemotherapy and, to a lesser extent, hormone therapy and immunotherapy. Radiation therapy is used both to cure cancer by destroying and eliminating cancer cells, and, where curing the cancer is not possible, as palliative treatment, which is the shrinking of tumors in order to reduce pain and other symptoms.

While we are all aware of the unfortunate prevalence of cancer, the statistics are nonetheless startling. According to the American Cancer Society, about seven million Americans have a history of cancer and about 76 million will eventually contract the disease. In 1991 alone, approximately 1.1 million Americans will be diagnosed as having cancer, excluding relatively minor forms of skin cancer. With an estimated one half of all cancer patients receiving radiation therapy according to the National Institutes of Health, it is clear that high-quality radiation therapy must be readily accessible to all Americans at a reasonable cost. Outpatient radiation therapy, such as that provided by Radiation Care, will play an increasingly important role in treating cancer patients.

Radiation Care, Inc.

Radiation Care opened its first radiation therapy center in June 1991 and currently has ten centers in operation or under development in Georgia, South Carolina, North Carolina, Virginia, Maryland, Tennessee and California. Radiation Care provides treatment to private and Medicare patients with about 30 percent of its revenues deriving from Medicare. Radiation Care's stockholders include some practicing medical oncologists and other physicians who may refer cancer patients whose condition requires radiation therapy to the company's centers.

Radiation Care has been designed from the ground up by some of the preeminent cancer treatment specialists in the country. It has also been designed with a sensitivity to the criticisms that are levelled at healthcare providers which include physician ownership, and with a goal to achieve compliance with the HHS Inspector General's safe harbors. The organization of radiation therapy centers is highly capital intensive, and the investment of physicians and others in the company was sought to provide needed capital. No potentially referring physician or other stockholder owns an interest in an individual center; every referring physician who is a stockholder has an interest in the company which is so minuscule as to negate any incentive to cloud his therapeutic judgement; and the method of remuneration for the company's radiation oncologists has been designed to avoid any incentive based upon volume or cost of services rendered.

A key element of Radiation Care's commitment to providing quality cancer treatment is to employ radiation oncologists with superior academic training and experience in their specialty. The choice of radiation oncologist is important, because it is he or she who, following a referral from a medical oncologist or other physician, ultimately decides whether radiation therapy is an appropriate treatment, prescribes the type and amount of therapy and supervises its administration. This responsibility makes the radiation oncologist the "gatekeeper" of radiation therapy.

Radiation Care encourages its radiation oncologists to participate actively not only in the local medical community served by the center under their supervision but also in the nationwide medical community. Many of the company's radiation oncologists have experience in teaching hospitals and the company requires them and supports their ability to keep abreast of and participate in developments in cancer research. In this respect Radiation Care is one of the pioneer users of "IMPAC" -- a cost-effective computer software system linking each of the Radiation Care centers. The primary function of the IMPAC system is quality assurance -- radiation treatments of each patient are recorded in great detail and are verified on a daily basis. There is also a nationwide data base containing a patient and tumor registry. Finally, the IMPAC system allows each Radiation Care center to be linked instantaneously to sophisticated, state-of-the-art radiation treatment planning. The IMPAC data base will provide cancer researchers with a wealth of data with which they can analyze how new medical technologies work in both university settings and in communities nationwide.

In short, Radiation Care is inalterably committed to becoming a major force in advancing cancer treatment in the United States.

Development of Outpatient Services and Joint Ventures

The focus of my testimony will be the Florida study on physician self-referral. I will begin with an overview of the Florida study and complete my testimony with a discussion of radiation therapy joint ventures.

In the course of my practice, I have represented various health care providers on a number of health issues, including the issue that has come to be known as physician self-referral. I have discussed this issue with many members of the Health and Oversight subcommittees and their staffs and look forward to continuing this dialogue. Because the federal government is the largest payor for medical services, the U.S. Congress in general and House Ways and Means and Senate Finance in particular have the right and responsibility to ensure that taxpayer dollars are well spent.

With technological advances, it is now possible safely to provide sophisticated services outside the traditional hospital setting on an "outpatient" basis with resulting substantial cost savings. Local physicians have identified the need for cost-effective, quality medical care in their communities. By pooling resources and sharing equipment, physicians have been able to make the substantial capital investments required to provide specialized services. By offering relatively few services, these new health care joint ventures can and have provided quality care at a reasonable cost.

As we all recognize, health care costs comprise a steadily increasing portion of the federal budget and our GNP. In a period of budget austerity and in a competitive world economy, it is vital that we control health care costs while ensuring that Americans receive quality medical services. At the outset, it is clear that there has been some abuse in the area of physician self-referral with a resulting increase in health care costs. It is fitting and proper for these two subcommittees to devote their attention to this issue. To the extent any problem is isolated, Congress shall first ascertain whether legislation is an appropriate cure, and, if so, it should be crafted to ensure that the cure is not worse than the disease. To stretch the metaphor, Congress shall clinically identify those areas where abuses occur and surgically address them. In areas where there is no significant documented evidence of abuse, there should be no consideration of legislation.

The Florida Study

The focus of today's hearing is the Florida Health Care Cost Containment Board's three-part study of physician joint ventures. The Florida legislature directed the Board to provide statistical data necessary to determine whether physician self-referrals generally result in patient abuse or over-utilization and, if so, to recommend legislation or other appropriate remedies. The Board is now in the initial stages of considering a recommendation for legislation addressing the subject.

The first phase of the Florida study reviewed published literature and surveyed the scope and nature of joint venture arrangements. The second and most publicized phase of the study statistically analyzed certain physician joint ventures. The study found substantial evidence of overutilization or abuse with respect to clinical laboratories, diagnostic imaging facilities and physical therapy facilities. It did not find substantial evidence of abuse or overutilization with respect to a variety of other areas, including radiation therapy and ambulatory surgery. The third phase of the study, which was circulated by the staff in draft form on October 11 to the Technical Advisory Panel (TAP) assisting the Board, contains the Board's legislative recommendations. The staff has tentatively advised the Board to recommend legislation prohibiting referrals with respect to clinical laboratories, diagnostic imaging facilities and physical therapy facilities. The Board is expected to consider and approve the third phase at its October 25 meeting.

There are many problems with the Florida study: in general, the Florida study does not identify the positive impacts that new health care joint ventures have had in three key areas -- cost, access and quality -- as was required by the legislature.

With regard to the first key area -- cost -- the study does not consider whether banning physician ownership of health care providers would reduce competition and raise costs. As physician-owned providers are eliminated from a particular service market, hospitals and nonphysician-owned providers will dominate the market. In particular, hospitals generally have had an economic incentive to forestall the growth of outpatient and home care and have often lagged behind in providing the latest technology until pushed by the competition. As these two subcommittees are well aware, hospitals often receive a higher Medicare/Medicaid reimbursement than outpatient providers for the same service or procedure. Against that background, it is hard to see how eliminating competition from many outpatient providers will reduce medical costs.

Nonphysician-owned providers often ignore smaller or niche markets that local physician providers now serve. Without competition from physician-owned providers, nonphysician-owned providers will dominate local markets and will raise prices. Indeed, the big, national reference laboratories were the strongest supporters and appear to be the principal beneficiaries of the federal legislation banning Medicare self-referrals to clinical laboratories effective January 1, 1992. The Florida study should have made at least a preliminary evaluation whether this legislation will result in the promised lower costs to medical consumers or whether it will merely reduce competition to the benefit of the national reference laboratories. Already, physician-owned laboratories have ceased operations in anticipation of the effective date and the General Accounting Office (GAO) has stated that the cost of laboratory services remains too high and that profits, particularly those of the large national reference laboratories, are excessive.

With regard to the second key area -- access -- the study's definition of access in terms of the relative percentage of Medicare, Medicaid and charity cases simply misses the mark. Such a mechanism leads to the absurd conclusion that access to health care is not increased by the addition of absolute capacity in a market, including increased services to Medicare, Medicaid and indigent people, where the facility may have a lower percentage of revenues devoted to those types of care than the existing nonphysician-owned facility. Nor does the study account for geographic location and demographic make-up of patient population. Rather, it concludes that any lower percentage of Medicare, Medicaid and indigent patients necessarily results from an effort to "skim the cream" from the provider market, a conclusion not proven by the data.

The study apparently assumes that restrictions on physician investment will not decrease the ability of the market to aggregate the capital and expertise necessary to form and operate medical service companies. This assumption is contrary to experience in the health care industry as well as other industries. In any industry a new company, particularly one that requires expensive new technologies, is formed and operated at least in part by those who are intimately familiar with the industry. Outside investors, such as venture capitalists, will be reluctant to finance new health care providers without some assurance of physician expertise and utilization base. Indeed, while the study notes that physician investment was high in specialties such as radiation therapy, it does not consider how quickly patients, particularly in smaller cities and rural areas, would obtain access to that treatment absent that physician investment. This is especially true of the major forms of cancer -- breast, colo-rectal and prostrate -- where radiation therapy often can save the organ. Restrictions on physician ownership will inhibit the formation of new companies and jeopardize existing physician joint ventures, thereby decreasing patient access to quality, reasonably priced health care. In the long term, patients will be forced to utilize their local and regional hospitals or nonphysician-owned providers, which eventually will purchase the same expensive new technologies.

With regard to the third key area -- quality -- the study merely reviews the credentials of provider personnel with respect to physical therapy services. No other treatment modality was scrutinized with respect to quality. The only correct way to measure quality is to utilize medically accepted methods to compare morbidity rates, recovery rates, treatment modalities and the like of nonphysician-owned and physician-owned facilities.

Nevertheless, for all its faults, the study does provide a much needed and valuable contribution to the collective learning on this important subject. It is one of the only studies on the subject and is by far the most comprehensive. Although the study fails to consider and recognize the beneficial effects of physician joint ventures on cost, access and quality, the study's data, though in many respects incomplete and misconstrued, confirm that in many specialties joint ventures have not had the negative effects alleged by their opponents. The study examined nine types of joint ventures: hospitals, nursing homes, ambulatory surgery centers, radiation therapy centers, home health agencies (excluding infusion therapy), durable medical equipment suppliers, physical therapy-rehabilitation centers, diagnostic imaging facilities and clinical laboratories. The study's results were negative only with respect to physical therapy centers, diagnostic imaging facilities and clinical laboratories. Significantly, the draft third phase of the study recommends legislation prohibiting physician self-referrals in only these three areas and states that a general ban on self-referrals "may have deleterious effect[s] on competition and the availability of services."

As I have pointed out, despite the limited staff recommendation on banning self-referrals and the recognition of the importance of competition among providers, the study generally "tilts" against joint ventures by ignoring their positive effects on cost, access and quality, while focusing on isolated abuses. In the three specialties where the study purports to have found clear evidence of abuse -- and others more familiar with those specialties can challenge that evidence -- the study does not consider whether eliminating joint ventures in those three areas would in fact improve cost, access and quality. Congress must avoid legislation that may have unanticipated side effects, even in those areas where the Florida study and other studies correctly document abuse, and carefully tailor statutes to address the problem at hand. Moreover, because of the study's bias against physician joint ventures, proponents of banning joint ventures in specialties where the study could not find conclusive evidence of abuse bear an especially heavy burden of persuasion. In those areas where there is no such evidence of abuse, the two subcommittees should recognize the positive role that physician investment has had in lowering costs, increasing access and improving quality.

The study purports to finds no clear evidence of abuse or overutilization with radiation therapy. The study notes that physicians own about 80 percent of Florida's freestanding radiation therapy facilities with radiation oncologists owning most of the facilities. The study apparently does not differentiate between facilities owned by radiation oncologists and those owned by referring physicians. The study also finds, but does not comment upon the conclusion, that nonphysician-owned facilities have a statistically significant greater number of procedures per patient than physician-owned facilities.

The study is clearly mistaken in its conclusions concerning the purported pricing differential between physician-owned and nonphysician-owned radiation therapy facilities. The study states that joint venture gross revenues are about $5,000 per patient while non-joint venture gross revenues are about $4,650. In its discussion of expenses and profit, however, the study admits that the data are unclear whether the reported expenses and profits derive from "facility services" (i.e., the "technical fees" only) or "facility services" plus "professional services" (i.e., the "global fees"). It should be obvious that the study's conclusion about the purported pricing differential is flatly wrong. It is impossible to reach any conclusion about comparative cost per patient without knowing whether the costs reported are complete or incomplete. It is Radiation Care's experience, moreover, that in nonphysician-owned facilities, the professional fee is billed separately by the radiation oncologist, leading to the conclusion that, in Florida, the total cost per patient, like the number of procedures, is actually higher in nonphysician-owned facilities than in physician-owned facilities.

The study's conclusions about the lack of overutilization and abuse, particularly with respect to radiation therapy and ambulatory surgery, are consistent with a general distinction between providers of diagnostic services and providers of most therapeutic services. Referring physicians typically have considerably more latitude in ordering diagnostic tests than they do in prescribing therapies such as radiation therapy, surgery, lithotripsy, dialysis and infusion therapy. "Over prescribing" diagnostic services is consistent with the practice of defensive medicine. Most therapies, on the other hand, must be medically necessary, and it is not surprising that there is no documented evidence that financial considerations are motivating physicians to prescribe improper treatment of serious illnesses. To illustrate, it is unthinkable that a person would undergo dialysis without end stage renal disease, lithotripsy without a visible kidney stone, surgery without a medically documented basis, infusion without documented proof of cancer, nutritional deficiency or infectious disease, or radiation therapy without a malignancy.[1]

Physician Joint Ventures and Radiation Therapy

Notwithstanding the fact that the well-publicized Florida study found no overutilization or abuse resulting from physician self-referral with respect to radiation therapy, it appears that the growth of Radiation Care and possibly other radiation therapy joint ventures has engendered competitive concerns among some radiation oncologists who are now seeking to convince Congress that the draft study's "no action" recommendation is incorrect.

The crux of the argument against radiation therapy joint ventures, as we understand it, is that (1) medical oncologists and other referring physicians will unnecessarily refer patients to radiation therapy facilities in which they have a financial interest and (2) radiation oncologists employed at those facilities will lack the independence to advise referring physicians when treatment is inappropriate and will always choose the most expensive treatment. This argument avoids facing up to the medical and economic constraints on the use and extent of radiation therapy and, by implication, calls into question these physicians' own ethical standards.

When considering restrictions on physician self-referral, it is essential to develop a full understanding of the nature of the specialty at issue and its referral process in order to ascertain the potential for abuse and overutilization. The process leading to a decision to utilize radiation therapy, surgery or chemotherapy or some combination of the three to treat cancer involves many participants and is subject to many restraints. Because the discretion of each participant is limited by the nature of the disease and treatment, the potential for abuse and overutilization is virtually negligible. Quite frankly, until the competitive concerns of those opposed to Radiation Care arose, Radiation Care had never heard the "mistreatment" allegation despite, according to the Florida study, the widespread existence of physician-owned radiation therapy facilities. We are compelled to state that this argument is so ridiculous and unfounded that it scarcely merits the dignity of a response.

As discussed, the "gatekeeper" of radiation therapy is the radiation oncologist who ultimately decides whether radiation therapy is an appropriate treatment and, if so, prescribes the type and amount of therapy and supervises its administration. It is not the "referring" physician. Although the radiation oncologist is the gatekeeper, his own discretion is generally limited by medical constraints that do not vary because of his financial relationship with the referring physician.

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[1] As indicated by the study, one exception to this general diagnostic-therapeutic distinction may be physical therapy. While the study states that patients treated at physician-owned physical therapy facilities averaged 43 percent more visits per patient than patients treated at non-physician-owned facilities, the study does not determine the cause of the increased visits to physician-owned facilities nor does it consider whether the increased visits resulted from better quality care. Even assuming evidence of overutilization and abuse with respect to physical therapy, that evidence does not extend to the "hard" therapies (e.g. radiation, ambulatory surgery, lithotripsy, dialysis and infusion). In contrast with the hard therapies, additional physical therapy generally is not harmful to the patient and the patient often requests additional treatment.

Typically a patient's primary care physician first will evaluate whether the patient has indications of a malignancy from symptoms and preliminary diagnostic tests. While occasionally the primary care physician will perform a biopsy, more often the primary care physician refers the patient to a surgical or medical subspecialist who will perform the biopsy. The biopsy will determine the existence and type of cancer. Further diagnostic tests determine whether it is widespread or localized. With this information, a team comprised of the patient's primary care physician, a medical oncologist, a surgical oncologist and a radiation oncologist will determine whether surgical removal, radiation or chemotherapy, or some combination of these, is most appropriate for the patient in light of a multitude of factors, including the patient's age and physical condition. Notwithstanding the consultative nature of the determination, the subspecialist who will provide therapy is ultimately responsible for the decision to proceed with that therapy. This consultative process ensures that a patient will not undergo surgery or receive chemotherapy or radiation therapy unless there is a medically documented need for such treatment.

From an economic perspective, and it is this perspective which critics allege is implicated in physician-owned facilities, the participation of a variety of physicians guards against the overuse of any one kind of treatment. Primary care physicians and surgical oncologists derive the most income from performing surgery; medical oncologists derive the most income from prescribing and overseeing chemotherapy; and radiation oncologists derive the most income from prescribing and overseeing radiation therapy. Of course, these physicians typically work together over the long-term and a physician who always recommended the most personally remunerative treatment soon would find himself frozen out of the consultative process. Moreover, even assuming that remuneration were the determining factor, a primary care physician, surgical oncologist or medical oncologist with a tiny percentage ownership interest in a company owning a radiation therapy facility would never recommend radiation because it would be massively more lucrative to provide personally the surgical service or chemotherapy, as the case may be.

Assuming radiation therapy is chosen as appropriate, the radiation oncologist will design the plan of treatment. With radiation therapy the key factors are the overall amount of radiation, the intensity of each daily treatment and the extent of targeted area. It is important to recognize that the radiation oncologist's discretion here is not unfettered. The radiation oncologist must balance the negative side-effects resulting from radiation's toxicity with the gains in the destruction of the tumor. In finding this balance, the radiation oncologist will rely on medically accepted guidelines for treatment contained in published literature and derived from his own clinical experience. The result is that if 10 different radiation oncologists reviewed the measurements and characteristics of 100 different patients and recommended a treatment plan for each one, the treatment plans for each patient would be remarkably similar, particularly in those cases where the goal is to cure the patient rather than merely relieve pain.

Thus the nature of both the referral process and the therapy itself minimizes the potential for abuse or overutilization. A patient will not receive radiation therapy unless there is a documented need for such treatment. We have seen that the "gatekeeper" of radiation therapy, the radiation oncologist, has little discretion in prescribing radiation therapy. This is true whether he owns the radiation therapy facility, is paid by a hospital on a fee-for-service basis, or is an employee and/or small percentage owner of a radiation therapy joint venture. Even assuming for the sake of argument that a radiation oncologist would or could act on a desire for personal financial gain, one who owns his own facility is in the position which has the greatest incentive to take advantage of his patients and the payor. Radiation oncologists who own their own facilities or receive fee-for-service payments from hospitals, particularly under exclusive consulting and treatment agreements, have no legitimate basis for questioning the ethics of their fellow radiation oncologists who are employed by and/or have small ownership interests in radiation therapy joint ventures.

Thank you for the opportunity to offer comments to the joint subcommittee. We appreciate the committee's commitment to study in-depth the full range of issues involved with respect to physician-owned providers. Dr. Hughes and I will be happy to answer any questions that you may have.

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Chairman PICKLE. Thank you.

Now we will hear Mr. Mardis.

STATEMENT OF HAL K. MARDIS, M.D., IMMEDIATE PAST PRESIDENT, AMERICAN LITHOTRIPSY SOCIETY

Dr. MARDIS. Yes, Mr. Chairman, thank you.

I am Hal Mardis. I am a urologist from Omaha, Nebr. I am a clinical professor of surgery at the University of Nebraska Medical Center, and I am medical director of the Stone Center at Nebraska Methodist Hospital which operates two extracorporeal lithotripters.

Neither I, nor any of the 38 urologists who utilize these instruments, have any financial interest in the machines or in the facility.

As immediate past president of the American Lithotripsy Society, I am here today to present our views on physician ownership and referral arrangements, as the issues arise in the field of extracorporeal shockwave lithotripsy.

The issue of physician ownership is obviously complex and contentious. Physicians disagree among themselves on the appropriateness of various arrangements. And the issue, obviously, has attracted legislative as well as regulatory attention, both here in Washington, and at the State level.

The American Lithotripsy Society firmly believes that physician ownership of lithotripters is generally motivated by a desire to expand the access of this compelling technology to our patients. It has literally revolutionized the treatment for our kidney stone patients, and we believe the decision by a urologist to use a lithotripter is clearly motivated by standards of medical practice, and not by a search for economic gain.

We do not believe that the Federal Government should prohibit physician ownership of all health facilities that may be used by their patients. Rather, we believe that the debate should be focused on how to govern these arrangements and prevent abuses, while preserving the benign and worthwhile ventures for our patients.

I do not intend to refute these criticisms we have heard today. I understand that abuses do occur. However, with lithotripters, the American Lithotripsy Society really has not encountered any clear problems that related to physician ownership. We hear a lot of problems of doctor-community-hospital politics, which obviously has occurred in Memphis, and we regret that, but that happens in many communities.

The recent publication of the safe harbor from the Office of the Inspector General seems to change the debate on physician ownership and referral. We really believe rules will have a profound effect on current business arrangements in the health care field.

And we urge Congress to wait on Federal legislative action until there has been an opportunity to evaluate the impact of these safe harbor rules.

The American Lithotripsy Society believes that many of the issues of concern to this committee will be addressed, once these rules are fully effective.

We believe that distinctions can be clearly drawn between therapeutic and diagnostic services. Therapeutic services will not be provided unless there is a demonstrated need, as Counselor Mills has noted. I am not going to put a patient of mine in a lithotripter if that patient does not have a kidney stone that needs to be treated.

Also, for therapeutic services utilization review and peer review safeguards are already well in place. We believe this substantially limits the potential for abuse.

That degree of certainty, perhaps, does not exist on the diagnostic side of the argument. As a general rule, we who work with lithotripsy treat our own patients with that machine, whether or not we have an ownership interest in that facility or not. We believe this greatly reduces potential for abuse. Lithotripsy really, from our standpoint, is a tool. It is an extension of our management of our patient, and the term "referral" does not seem appropriate, as we view the way these machines are handled.

In conclusion, Mr. Chairman, the American Lithotripsy Society does believe that physician ownership of lithotripters has helped and facilitated patient access to this splendid technology. And we believe that distinctions can and should be drawn between therapeutic, such as lithotripter installations, and diagnostic services, when examining these issues of physician ownership and referral.

Finally, we do urge you to evaluate fully the impact of the safe harbor rules before enacting further legislation regulating physician ownership and referral.

I thank you very much for your time and attention. Mr. Chairman, I would be pleased to answer any of your questions.

[The prepared statement follows:]

STATEMENT OF THE
AMERICAN LITHOTRIPSY SOCIETY
TO THE
SUBCOMMITTEE ON HEALTH
AND THE
SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

PRESENTED BY
HAL K. MARDIS, M.D.
OCTOBER 17, 1991
RE: PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

Mr. Chairman and Members of the Subcommittees:
My name is Hal K. Mardis, M.D. I am a urologist who practices in Omaha, Nebraska, and I am the Immediate Past President of the American Lithotripsy Society (ALS). I am here today to present the views of ALS on physician ownership and referral arrangements, particularly as these issues arise in extracorporeal shockwave lithotripsy centers. Many of the members of ALS have an ownership interest in lithotripsy centers. They are keenly interested in the discussions before this Committee, and I am pleased to have the opportunity to represent them here today.

ALS was first established in 1987. Its focus since its inception has been the training, continuing education and assurance of quality of care for urologists, nurses, radiology technicians and other health professionals involved in offering lithotripsy services to patients in this country. In fact, one of the issues that led to the organization of ALS was the need to establish standards of quality assurance for lithotripsy centers.

The issue of physician ownership of health facilities and services to which they refer patients is complex and contentious. Physicians differ among themselves on the appropriateness of different kinds of arrangements. These issues have attracted legislative and regulatory attention here in Washington and also at the state government level. The recent publication of final "safe harbor" rules by the Inspector General of the Department of Health and Human Services will have a profound impact on a host of business relationships in the health care field. Physicians who have a financial interest in lithotripsy will also be affected by these "safe harbor" rules.

ALS does not believe the federal government should entirely prohibit physician ownership of health facilities and services that may be used by their patients. Rather, the debate should focus on how to govern such arrangements to prevent abuses and preserve their benefits to patients.

ALS also urges you to delay any further legislative action until we can all judge the impact of the new "safe harbor" rules. These regulations may well address many of the concerns raised and ALS urges Congress to evaluate the results before enacting new controls.

Many witnesses before you will offer their view of the problems with physician ownership and referral. ALS does not intend to try to refute every criticism because we believe there have been problems and they need to be addressed. ALS hopes to show you today that physician ownership of lithotripsy has generally been a positive factor in expanding the access of patients to what is widely regarded as an excellent new technology.

Lithotripsy is one of the most revolutionary technologies in medical history. It permits non-invasive crushing of painful kidney stones and has transformed the treatment for individuals who suffer from kidney stones. As anyone who has ever suffered from a kidney stone can attest, the pain can be excruciating and disabling. The previous techniques were much less satisfactory because they either took too long to be successful, during which time the patient suffered, or exposed the patient to surgical risk. Since lithotripsy was introduced in this country from Europe in 1984, the need for invasive surgery in over 90% of kidney stones has vanished. Although expensive to install and operate, lithotripsy has helped thousands of men, women and children in this country avoid the pain, suffering, surgical risk, and rehabilitation time and expense that was common in these patients prior to 1984. ALS believes that lithotripsy has proven itself both medically and economically effective.

Lithotripsy is the accepted treatment for most kidney stones. Thus, the choice of urologists to use lithotripsy to treat kidney stones is driven by standard medical practice, not economic gain. There is no better alternative treatment for most stones that urologists could choose.

Physician ownership of lithotripsy, including freestanding units or mobile units which can be moved from one hospital site to another, is common. ALS estimates that there are over 400 machines operating in this country and a significant percentage of them are owned in whole or in part by physicians, primarily urologists, who use lithotripsy to treat their patients. Physician ownership of lithotripsy is not universal and varies from state to state. Contrary to widely held opinion, not all physician owned lithotripters are profitable ventures. Although many groups have done well, others are not succeeding.

Although the business arrangements are varied, the usual pattern is for the urologist owners to provide services at the site to their own patients once the determination has been made that a kidney stone is present and that lithotripsy is appropriate. These urologists treat their own patients as a general rule. Urologists do not have to be owners to use lithotripsy units for their own patients. If trained in lithotripsy, they may use the unit to treat their patients. These urologists who do not themselves perform lithotripsy refer their patients to a hospital or a free standing center for treatment and physicians trained in lithotripsy will perform the services for those patients.

ALS believes that there are important distinctions between lithotripsy ownership and some of the other ownership and referral arrangements that have been criticized in reports by the General Accounting Office (GAO), the Department of Health and Human Services Office of Inspector General, and the State of Florida Health Care Cost Containment Board. A particularly critical one is the fact that the urologist investors in lithotripsy units are commonly the physicians who treat their own patients. They do not "refer" to another physician. We believe that the potential for abuse is largely eliminated when the owner/investor also performs the service. In such cases, the term "referral" is really not appropriate. The lithotripsy center is an extension of the physician's office, the place where the urologist provides a medically necessary service for his or her own patients.

ALS believes that another distinction exists between therapeutic services, such as lithotripsy, and diagnostic services, such as radiology or clinical laboratory services, which as Members of Congress should consider as they try to determine what stance to take on physician ownership and referral. We believe that a clear delineation can and should be made between diagnostic services and therapeutic services. ALS believes that many of the abuses that can arise from referral by physician owners are minimized in the therapeutic setting, such as lithotripsy. First, the patient either has a kidney stone or does not. This is determined by the intravenous pyelogram and the KUB, two diagnostic tests that show if a stone is present or not. If no stone is found, then the patient will not be treated. Most patients who wind up having lithotripsy have been referred to the urologist by another physician, perhaps their internist or family physician. Thus, there has already been one previous level of review of the problem.

Additionally, most mobile lithotripsy units are serving hospital out-patients. Thus, the records of treatment are reviewed by the hospital utilization review committees. For Medicare patients, the peer review organizations review the charts. If there is uncertainty as to whether the patient should have received the treatment, there are safeguards that already exist to deal with that issue. There is no question that in some diagnostic areas there is much less certainty and the opportunity for abusive practices exists. ALS believes that few physicians take those opportunities, but the lack of certainty of diagnoses and the lack of utilization review makes it easier to "game the system".

The expense of the technology is significant. The average cost of a ESWL unit ranges from $1.5 to $2 million. Due to the need for this capital investment, a single hospital, especially one outside a major metropolitan area, is unlikely to purchase a machine solely for its own use. It simply is not going to have enough stone patients to defray the costs. Therefore, systems have evolved to expand the population that can be served by a single machine. Since all urologists desire to make this technology readily available to their kidney stone patients, it made sense in terms of patient access and the economics of the machinery for many urologists to band together in various ventures to own the equipment. Some of these arrangements involve joint ventures between physicians and hospitals. Others are physician only organizations. Still others involve a group of urologists and another corporate investor. There is great variety among these investments and arrangements. The development of mobile units allowed a single machine to serve a much larger population. This has greatly increased patient access and has meant that lithotripsy has become widely available without forcing patients to travel great distances to a few sites in the largest cities.

Since 1984 when lithotripsy first entered this country, physician ownership has helped expand the availability and accessibility of this technology to almost all patients suffering from stone disease. The result has been a substantial reduction in surgical procedures to treat these diseases with greatly improved outcome and greatly reduced morbidity and mortality.

We believe that lithotripsy is clearly different from the other areas of physician ownership and referral that have been examined by the government and found to have problems. In order to assure that similar problems can be avoided in the ownership of lithotripsy centers, ALS has endorsed the guidelines of the American Medical Association on physician ownership and referral. We encourage urologists who are owner/investors in lithotripsy to treat their own patients, whenever possible. Finally, we believe that the physicians who use lithotripsy must demonstrate their competency before being allowed to use the machine, whether they are investors or not.

In conclusion, ALS acknowledges that physician ownership and referral has raised significant questions within the medical profession and in government circles. However, ALS does not believe the government should outlaw ownership of therapeutic modalities, particularly where those modalities are being applied by the owners themselves. We urge the Subcommittees to give careful consideration to these views and to decide to draw a "brightline" between therapy and diagnosis when examining physician ownership and referral questions. We also urge you to evaluate the results of the "safe harbor" rules before enacting new legislation. Finally, if legislation is required, ALS wants to be part of any discussions and negotiations in order to contribute its best advice on how to regulate physician ownership and referral to end abuses, while preserving benefits where they exist.

Thank you for your time and attention. I would be pleased to answer any questions that the Subcommittees might have.

Chairman PICKLE. I thank this panel.

Did you have any statement, or are you just there with Mr. Mills?

Dr. HUGHES. I would love to make a statement, Mr. Chairman.

I am Dr. Edward Hughes. I am currently a practicing radiation oncologist in Charlotte, N.C., as well as being the medical director for Radiation Care, Inc., which has a number of centers throughout, mostly, the Southeast.

You heard a lot of comments here today, both hypotheses—you heard some hypotheses from Dr. Schwade about overutilization and the potential for overutilization.

You heard Mr. Mills say that it is inconceivable that a radiation oncologist would overtreat a cancer patient.

Let us come back to Dr. Schwade's comments, and let me just take one major exception, in that I find it scurrilous that these allegations have been made, and they are tantamount—and pardon this analogy—to a high-tech lynching of our profession.

I hope that he comes forward with specific data, and I think that is the issue today. What are the data, specifically about overutilization?

I can speak only for my experience, in my center, at Charlotte Radiation Care, and also for the other facilities we have throughout the southeast part of this country.

Dr. Schwade referred to the Patterns of Care Study, which specifically addressed one form of overutilization, and that was the negative consult rate, or rather, those patients who have cancer who are consulted in a radiation oncology department but eventually do not come to any form of radiotherapy treatment.

I have performed an analysis of our radiation care centers throughout the Southeast, and I can say to you, of no surprise to anyone, that our numbers are exactly the same. The study was identical, and our numbers are exactly the same as that found in the Patterns of Care Study, which went on a much broader base throughout the rest of the country.

The Patterns of Care Study showed that about 15 to 20 percent of patients who are referred to radiation oncology departments are not treated with radiation therapy. We found the same thing throughout all our centers. The range was 13.8 to 21 percent, and the average was 15.8 percent. Again, no surprise to anyone.

Chairman PICKLE. Well, I thank the panel, and I think it is good to have these statements on the record.

I said earlier, and I guess I am in general accord with Mr. Mills, and you, Doctor, that I cannot imagine a physician prescribing radiation or chemotherapy, or lithotripsy if it is not for a condition that has to be treated. Otherwise, he would not prescribe it. Anybody that does that would be guilty of violating his oath, and ought to be removed from the practice of medicine.

We will try to get information on that if we can find it. It ought to be investigated if there was overutilization. I think what they were saying is that studies show that when you do have physician-owned clinical labs, or MRIs at diagnostic centers, that the volume seems to go up. And the facts seem to show that.

I think the Florida survey will be very helpful. I do not think we can ignore it or say that is just a bunch of Florida State University professors playing with a little study. Apparently there is a tendency for higher utilization, and they made that clear this morning, that it was higher, and it was not overutilization.

But, if we are going to narrow it down, as you have pointed out, there is not going to be overutilization with respect to radiation or chemotherapy or lithotripsy. I would agree with you.

If there is anything that can prove to the contrary, I would like to have facts on it, and I invite any of the panelists to give us indications. We are not trying to "string somebody up," but we want to try to get the facts involved. Because if that condition does exist, we ought to know about it.

The real question is, is physician-referral bad per se? I do not think it is. I do think that as new machines are created and built, more and more of these facilities will be available. I think the price is going to be coming down.

Price is a tremendous factor, and if there is no competition, we have to do something about it. Now, I personally defend the right of a physician to have a part in these facilities. I do not think we would have many of them if they were not willing to make the investment.

But I think they also make it because it is also a good business proposition, and to not admit that is to say that they do not want to make money. That is not reality. But I think we have to be sure that the physicians must not overutilize services at the facilities they own.

I agree with you, Mr. Mills, that there is a great deal of difference between a referring physician and a treating physician, like a radiologist, or the urologist, within a hospital. But a physician in the hospital, who is a referring physician, does turn over to the radiologist, or the oncologist, the question of radiation and the treatment, and he does not have anything to do with it.

So if there are abuses, it would be, perhaps, by the treating doctors—the radiologists or the oncologists, rather than by the referring physician.

Let me be more specific.

I have been a patient myself, and I went to a hospital. I was referred by a referring physician. Once that physician referred me to the radiology department, he had nothing to do with the case, relatively speaking, except, I hope and pray, they checked the data with him. But he also was on travel a lot of time after that.

I was totally in the hands of my radiologist, but I felt secure about it. And I do not think that radiologist was profiteering from it. I do not believe that at all.

So I do think it is important for that distinction to be made. But I also think that physicians, as a whole, have a tendency to be willing to make a little extra money if they can, and the facts show that this is occurring. I think physicians want to get a right charge.

I know that they have the confidence of their patients, and I do not think it is going to make much difference to the average patient where his doctor refers him, because that patient is probably going to go if he has confidence in that doctor. And it is not a bad practice either, because confidence is probably the most important thing.

In these hearings today, we received a lot of conflicting information. I think my last question would be to you, since the HCFA, or the inspector general, has set up these safe harbor rules, they have been in effect, now, how long?

Mr. MILLS. A month, month and a half.

Chairman PICKLE. All right—just started. So we do not know, at this point, whether they are working, or are going to work, or they are the right approach. At least I do not. I think we should be careful. I do not think we ought to be timid about it, but I would want to see—is that a fair approach. And if that is not a fair approach, then the next question is can we change that formula, or should we look in some other direction?

How much time will be required to wait to see, I am not sure. But I do not think we have to wait any 2 or 3 years. I think we can know fairly soon whether this is a good approach or not.

Do any of you have any additional statements?

Mr. Mills.

Mr. MILLS. Mr. Chairman, I would like to respond to the last point about the safe harbors.

Without endorsing the safe harbors as properly indicative of the underlying antikickback law—and I note that earlier Chairman Stark, I think, made exactly that point. Nevertheless, their impact on physician joint ventures is, and will be, profound. We do not know, yet, the impact, but we know that it is tremendous.

I think that they—insofar as Medicare is concerned, because they, like this committee's jurisdiction, are limited to Medicare—will have an effect. I also think that since they have changed from their draft form, and with the continuing interpretation, and the continuing fraud alerts, and now possible broad-based physician self-referral legislation, we have an enormously moving ballpark.

I think that, as in the Tax Code, sometimes we have to just stop and see what happens.

Chairman PICKLE. Well, we are stopping, but I do not think we are going to pause long to try to make an evaluation of these new safe harbor rules, and I hope we get in some data quickly.

More than referrals, or self-referrals, the biggest health question we have to face concerns the overly awesome, burdensome costs. When I think in terms of what it costs to go to physicians to be examined, to have CT scans, to have MRIs, to have bone scans, and all the other things—it takes a rich man to be able to pay those bills. The average person cannot do it.

I know when I get my bill, it is going to be like a mountain. I ask myself, how can the average person pay for this? I am not as worried about self-referral as I am worried about how individuals in the country can pay their medical bills? That is our problem.

I do not guess I know the solution to that, or does anybody else. Except that is the problem. So, the question of money, and costs, and profits does enter into it, and we have to be mindful of that.

Well, I thank you very much for your attendance.

I want to say that this concludes this subcommittee's hearing.

[Whereupon, at 3:20 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF JERE W. GLOVER, PRESIDENT, ALLIANCE FOR AFFORDABLE HEALTH CARE PRESENTED TO THE SUBCOMMITTEE ON HEALTH AND THE SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, UNITED STATES HOUSE OF REPRESENTATIVES, HOLDING A HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS, OCTOBER 17, 1991

Mr. Chairman:

I would like to commend the Committees for holding this hearing and express my appreciation for the opportunity to present our views on this issue.

My name is Jere Glover and I am President of the Alliance for Affordable Health Care.

Our primary objective is to help make affordable health care available to our more than 30,000 members and to all Americans.

Just obtaining adequate health insurance is a difficult enough task today. Finding and obtaining health care coverage at an affordable price is even more difficult and for far too many of our citizens, impossible.

Although there may be wide disagreement on what the root cause of the problem is with our health care system, the extent of the problem and the best way to solve it, there is absolutely no disagreement that health care costs are out of control.

You are all too familiar with the factors escalating these costs and there is no need for me to repeat them here.

However, none of the reasons fueling spiraling costs is more unacceptable nor more unpalatable than that of overcharging by providers. And there are few if any more glaring examples of this practice than the case of Memphis urologists who have created a virtual monopoly on lithotripter services in their area.

It is our understanding, Mr. Chairman, that nearly all of the urologists in the Memphis area who are qualified to perform this service have become partners in a business venture that owns a new model lithotripter -- a machine that removes kidney stones without surgery.

The urologists who formerly used a lithotripter located at a Memphis hospital reportedly have stopped using that machine and instead are now referring patients to the facility which houses the lithotripter in which they have a vested interest and may, in fact, own. Lack of referrals has apparently put the lithotripter at the hospital out of business.

When these same urologists performed essentially the same procedure on the hospital lithotripter, the cost to the patient ranged from $3,300 to $3,600. The hopital's "old" lithotripter had been upgraded to be anesthesia-free and was a "state-of-the-art" lithotripter. The standard fee now being charged by these same urologists is reportedly over $7,000, twice the former charge.

Insurers in Memphis contend the fee now being charged is exorbitant, that it far exceeds a reasonable charge for the service, and the insurers are refusing to pay.

We agree. I can tell you from personal knowledge and experience that the $7,000 fee is exorbitant. A business venture with which I am affiliated runs a lithotripter in Maryland.

The State of Maryland evaluated the costs involved in purchasing and operating a lithotripter and established a State-regulated fee of $1,681 for lithotripter services. A copy of the staff analysis is attached for your information to show how the fee was determined. For more information about the Maryland analysis of lithotripter cost, you can contact Lynn Garrison at (301) 764-2605.

I must tell you, Mr. Chairman, at $1,681 a treatment, we are making a most acceptable profit on our investment. And I submit to you that the doctors and other investors in the older-model lithotripter used by the Memphis urologists until earlier this year were making a tidy profit by charging patients a fee in the $3,000 range.

Doubling the charge to over $7,000 is unconscionable price gouging.

It is obvious that the chief beneficiaries of the new lithotripter in Memphis are not the Memphians who require its use but rather the doctor-investors who control the demand for its use and supply the service it provides.

It is equally obvious, Mr. Chairman, that the chief victims of this unacceptable arrangement by the Memphis urologists are the people who require lithotripsy treatment. Treatment of kidney stones is not an elective procedure. In most cases, the patient cannot defer treatment in hopes the condition will improve or correct itself.

In the case of patients in Memphis, they are being victimized by the virtual monopoly the business venture apparently has created for the Memphis physicians involved.

Secondly, we understand that the company which helped organize the partnership of the Memphis urologists that operates the lithotripter reportedly is repeating the same type of business arrangement for doctors in other states and has helped place new lithotripters in at least a dozen other locations throughout the country. Patients in those states could be victimized just as those in Memphis are.

The most discouraging aspect is that people who may truly need lithotripsy treatment but cannot afford the exorbitant fee, are being forced to painfully delay or forego treatment or travel to distant areas for treatment that they may be able to afford.

The entire matter deeply concerns us at the Alliance for Affordable Health Care. We are striving to drive health care costs down, not up. Escalating health care costs, some of which may, unfortunately, be legitimate, should not be further aggravated by unethical or blatant abuse of overcharging by physicians or other providers.

The Alliance for Affordable Health Care will continue to seize every opportunity it can to help contain health care costs and achieve our primary goal of affordable health care for our members and for all Americans.

We look forward to working with you and your committees to achieve that purpose.

Thank you.

7) on

RE: THE RATE APPLICATION * BEFORE THE HEALTH SERVICES COST
OF AMI DOCTORS' HOSPITAL OF * REVIEW COMMISSION
PRINCE GEORGE'S COUNTY * Docket: 1986
* Page: 534
* Proceeding No.: 724N

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STAFF RECOMMENDATION

AUGUST 18, 1986

$ 1,375.40/TEST

On July 31, 1986 AMI Doctors' Hospital submitted a rate application for a new Lithotripsy service (Extracorporeal Shock Wave Lithotripsy or ESWL). The hospital has requested a rate of $2,077.62 per ESWL procedure effective October 1, 1986 and a rate of $1,819.48 per procedure effective October 1, 1987. The hospital has requested these rates based upon 700 procedures in Year 1 and 850 procedures in Year 2.

In addition to requesting these rates, the hospital also asks that the lithotripsy rate be 100% variable, that the service be treated as if over 75% of patients will be private ambulatory such that the private ambulatory charges are not financed from the hospital's new service dollars (or count toward future new service dollars), that subsequently admitted patients be assigned the appropriate non-surgical kidney stone GIR classification while the Lithotripter service is treated as a separate ambulatory charge, and, as with MRI, the lithotripter rate be adjusted for inflation but not be rate realigned until a hospital's rate review system includes a full year's data for the second time.

I. Background

This is the first rate request the HSCRC has received for ESWL services. This service is no longer subject to Certificate of Need and the HRPC has not, and indicates it will not, adopt any standards regarding ESWL into the State Health Plan. Appendix One is a brief description of ESWL by the NCHSR.

This is the first ESWL application in part because the other ESWL service in the state, the Maryland Kidney Stone Center, while owned by hospitals is not itself a hospital nor is it on hospital grounds. In addition, this is first, in part, because AMI International has already ordered six lithotripters and will assign one to their Maryland hospital if the rate approved in the proceeding makes that decision appropriate. Four of the six are already placed at AMI hospitals and the last two are reportedly due for delivery to the United States in October and November.

The HSCRC's responsibility is to approve a reasonable rate reflecting efficient and effective service.

Review

The Commission's policy for approval of rates for new services uses the median as a standard of reasonableness. The approved rate may differ from the median for certain reasons including projections of lower cost during the Certificate of Need process, changes in the Commission's accounting and reporting system, etc. Clearly, this review can apply neither the median nor the State Health Plan.

The Maryland Hospital Association has proposed that the HSCRC develop price standards. The HSCRC has previously developed a price standard for MRI services. This review may be seen as the development of a price standard for ESWL services. The HSCRC is also developing price standards for a standard case. In the development of price standards the HSCRC has been urged, and the Commission's staff has proposed, that except for taxes other than corporate profits taxes, the same price standard be developed for not-for-profit hospitals as for proprietary hospitals. No distinction was made in the price standard for MRI services. The Holy Cross MRI recommendation included some special consideration due to the financing available in that circumstance. We make a similar recommendation here. That adjustment is outside the price standard.

The HSCRC earlier proposed objective standards for proprietary hospitals. At the hearing before the AELR committee those hospitals indicated they did not want a separate price standard. The HSCRC staff indicated that we are prepared to recommend one price standard but that if proprietary hospitals request more than the proposed standard for one element of cost, then the staff would review all elements of cost as they relate to a full examination of fair return on fair value as that term has been applied in Maryland and approved by the Court of Appeals in the P.G. Doctor's case. Thus, for example the HSCRC would offer to develop a separate rate standard which fully applies the public utility model - such as eliminating inflation on depreciation, paying zero after an asset is fully depreciated, basing a rate upon an appropriate debt/equity ratio with appropriate interest rate and return on equity, basing the depreciation on actual cost, treating working capital as part of equity, etc. The staff references Mark Pauly's "Returns on Equity for Not-For-Profit Hospitals", Health Services Research, April, 1986 in which he argues that higher rates should be approved for proprietary hospitals only if one has a positive need for proprietary hospitals. We do not have a positive or negative feeling toward proprietary hospitals, do not know if a second lithotripter is needed in Maryland and have no reason to believe that if it were needed, a not-for-profit hospital would not choose to offer the service. We, therefore, believe we should have one price standard. Further, we believe the rate proposed here will allow AMI P.G. Doctor's Hospital, if it is an efficient and effective hospital, to earn a fair return on fair value as per the public utility requirement.

The standards being developed and proposed in this recommendation are meant to apply equally to all hospitals. Some discussion will be included to reflect where differences might be made if the applicant wishes special consideration due to its for profit status.

The cost of ESWL hospital services consist of three parts: capital costs, direct operating costs and indirect costs. These areas are reviewed in turn.

A. Capital Costs

ESWLs are currently very expensive machines. The only ESWL with Food and Drug Administration approval is manufactured by Dornier Systems, Friedrichshafen, West Germany. The rate application and literature indicates that lithotripters have been paid for in West German currency, the German mark (DM). Purchase price in American dollars has varied with the exchange rate. The rate application notes that according to the Office of Technology Assessment, the average cost over the past year was approximately \$1,700,000.[1] The OTA study is dated May, 1986, but according to the study director, the year referred to was calendar year 1985. Thus, if the Hospital's arguement were correct, the twelve month inflation in exchange rate requested in the application would be insufficient. The July 1, 1985 price for the DM was 0.3342. The August 6, 1986 price was 0.4894. Thus, $2,490,000 would be required now to purchase the same number of DMs that could be purchased for $1,700,000 on July 1, 1985.

After establishing this exchange rate effect, the staff spoke with David Heiden, Vice President for Sales and Marketing, Dornier Medical Systems in Marrietta, Georgia. Mr. Heiden reported the Dornier lithotripters are currently being sold in American dollars for $1,700,000 - $1,800,000 plus 9.4% customs duty (see Appendix II). The customs duty is waived for non-profit entities. He further noted that past purchasers who contracted in DM were advised to hedge so they would not be affected by exchange rate fluctuations. In light of the above and contrary to the information in the rate application, the present value-purchase price of the ESWL is $1,800,000 (The staff and Commission have always held that taxes, other than corporate profit taxes, paid by proprietary hospitals are appropriate additions to the rates that would be approved for a non-profit hospital. We, therefore, recommend that $169,200, 9.4% of $1,800,000, be capitalized into the price of the lithotripter for this application.) The resulting amount, as per August 1, 1986 is $1,969,200.

The second element of capital costs is installation costs. The average cost reported by the OTA was $375,000 but the average included amounts clearly not related to ESWL. The AHA estimates installation costs at $250,000, Dornier at $100,000 and Blue Cross $175,000.[2] OTA itself wrote "the total fixed, capital cost of purchasing and installing a Dornier lithotripter at present is around $2,000,000" (Appendix III, page 46). The staff recommends an average between the AHA and Blue Cross amounts or $212,500. (Fixed here is used in the economic sense and includes moveable equipment).

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[2] See Appendix III

The Commission staff is first inflating all cost elements to August 1, 1986. In actually establishing a rate for the year beginning October 1, 1986, the August 1 price standard will be price leveled to April 1, 1987, the middle of the price year. The August 1, 1986 installation cost is $220,100.

The rate application also notes that additional moveable equipment is needed beside the lithotripter and that the cost of that equipment to P.G. Doctors' was approximately $260,000. Some reasonable estimate for this element would have to be added if it were not included in either the lithotripter price or the renovation/preparedness prices. If this additional equipment were used to perform other tests for which charges were made and RVUs generated, then that equipment should not be included in the lithotripter rate or there would be double billing for this ancillary equipment. The staff has been advised that the vast bulk of the equipment in Attachment 3 is to perform separate x-rays which would generate their own bills. The remaining amount may be included in refurbishing and renovation costs. We include $80,000.

In order to translate capital purchase prices into a price standard, it is necessary to establish the useful life of the assets. The useful life we recommend for the renovation cost is 15 years as was used in the MRI application. The useful life we recommend for the auxiliary equipment is 10 years as per the Commission's standard equipment life methodology.

In developing a recommendation for the useful life of the lithotripter, the staff has reviewed the literature, spoken to various agencies with responsibility, and considered the relationship of depreciation or useful life determinations to payment in the Commission's system v. other systems such as Medicare and Blue Cross cost reimbursement systems.

The literature reflects five year lives used by OTA and Blue Cross of America. The AHA report referenced in this recommendation also uses a five year life. The staff has contacted the Health Care Financing Administration to see if HCFA has made a determination. HCFA indicated that they use AHA lives when those are published but no life for a lithotripter is currently published or expected to be published shortly. In the mean time, HCFA will rely on intermediaries. HCFA also suggested contacting the manufacturer. Subsequent to staff conversations with HCFA, Bob Hauck of Blue Cross and Blue Shield of Maryland's Medicare intermediary branch has been advised by HCFA that an eight year life is to be used. Our contacts with AHA have determined that the debate is between the five years providers want and the ten years the manufacturer claims. While this was the information we received from AHA, Mr. Heiden of Dornier suggested that most places use five years. The machine will last well beyond five years but is subject to obsolescense. He said the machine is planned so it can be adapted to technological changes. We have also been advised that some intermediaries are suggesting eight years. Subsequent conversations with the Massachusetts Rate Setting Commission (regarding Massachusetts General's lithotripter) and with AHA all reflect use of 5 years.

In selecting a useful life, it is important to reflect upon the different effect the life of the asset has on payments under Medicare's capital pass-through method or Blue Cross or Medicaid cost reimbursement methods and the HSCRC's system.

Under cost reimbursement, the useful life determines how soon the purchaser will get back the purchase price. For example, if a piece of equipment costs $1,000,000 and is used for seven years, the annual depreciation payments based upon a four year life are $250,000, $250,000, $250,000, $250,000, zero, zero and zero. If a five year life were used, the annual depreciation payments would be $200,000 for the first five years and zero for the last two years. The point is that the payer is only at risk for some cash flow but, in either case, the total dollars equal the purchase price.

In the HSCRC system, once a price standard is developed, that payment continues over time and inflates. Thus, if we were to approve a depreciation basis of $250,000 for the above equipment, rather than four $250,000 cost amounts and three zero cost amounts, the Commission system would allow (assuming 4% inflation and seven year use as above) $250,000; $260,000; $270,400; $281,216; $292,465; $304,163 and $316,330. Rather than total payments of $1,000,000 the total payments would be $1,974,574. In the five year life example, the annual payments would be $200,000; $208,000; $216,320; $224,973; $233,972; $243,331; and $253,064 for a total of $1,579,660. Thus, in the HSCRC system, underestimating the life of an asset puts the payors at serious risk. The brisk trade in fully depreciated used high tech short-life pieces of equipment such as CT scanners suggests that the AHA life is often shorter than the useful life. That is acceptable when out year payments are zero and annual amounts do not inflate. It is unacceptable as a general rule under the HSCRC system.

In establishing payment for most pieces of equipment, the HSCRC provides replacement cost depreciation based upon a ten year life. An independent audit performed for the HSCRC showned that the average AHA life of equipment is very close - only slightly greater than ten years - and the Maryland hospital industry, when offered the option of switching to AHA lives on individual pieces of equipment from using the ten year average, opted for the simplicity of the ten year average. The standard HSCRC equipment payment system does not include interest on equipment because replacement cost depreciation funds a cash purchase. The Commission, and its staff, have indicated that the decision to pay cash, lease, or borrow to purchase equipment is a business decision that should not affect price. Given the tax laws, it often pays non-profit hospitals to borrow at tax exempt rates while placing their depreciation funds in taxable investments.

The Commission has made two previous exceptions to the ten year average life - we use 6.5 years for CT scanners and 6 years for MRI. We also made one exception to the general rule of defining cost as replacement cost depreciation. That was in the MRI standard where we defined cost for the initial price standard as debt service assuming

100% financing through the Maryland Health and Higher Education Facilities Authority (MHEFA). The Commission and staff felt that this new expensive piece of equipment could not be purchased out of depreciation on other equipment and the cash flow needs of an efficient hospital should be met. The MHEFA equipment program allows a loan with an average life equal to the composite of the equipment and associated construction.

The applicant has proposed a similar structure in the ESWL standard as in the MRI standards with one exception. The applicant requests a 10% interest rate on 100% financing because, as a for profit hospital, it is not eligible for a MHEFA loan. The applicant has also requested a 5 year life based upon the literature.

OK The staff is recommending a five year life though we recognize the potential problem associated with this recommendation. This will require a change from our current regulations which establish a 10 year life for all equipment but CTs and MRIs. We recommend such a change be made as an emergency measure.

The staff also recommends that we continue to use the basic structure of the MRI recommendation which is to give great weight to the MHEFA interest rate in developing a price standard.

The composite life for price standard purposes is as follows:

Lithotripter	$1,800,000	x 5 years =	9,000,000
Construction	220,100	x 15 years =	3,301,500
Associated Equipment	80,000	x 10 years =	800,000
	$2,100,100		13,101,500

13,101,500/2,100,100 = 6.2 years

According to Charles Saunders of MHEFA, current cost to borrowers of equipment loans is 5.1%. Some borrowers have to secure a line of credit which costs 1 - 1.5%. Less than half the borrowed amounts are affected by this added cost. On balance, the Commission's staff is proposing to include in the price standard the annual debt service on a seven year loan of $2,100,100 at 6% paid semi-annually. That amount is $422,000. The staff proposes this as the appropriate capital cost as of August 1, 1986.

The Commission has previously found that prime plus 2% is a reasonable interest rate for proprietary hospitals. If one hundred percent financing is appropriate - as suggested and requested, then the 10% interest rate is appropriate. The annual debt service on $2,269,300 at 10% for 6 years is $512,100. (Of course, we do not imply by this statement that P.G. Doctors' has spent $2,269,300 on lithotripter specific capital.) As in the Holy Cross MRI proceeding, given the circumstances of the particular financing, the staff recommends that the rate for AMI P.G. Doctors' be based upon capital cost of $512,100 as per August 1, 1986.

B. Direct Operating Costs

In reviewing operating costs, in addition to the OTA, AHA and NCHSR references, the staff has reviewed studies by ProPAC and the Institute for Health Policy Analysis at Georgetown University Medical Center. (See Appendix Three for selected pages).

1. Maintenance

The Commission has recently defined maintenance contracts as a direct cost in the specific revenue center with the equipment to be maintained.

As noted in the rate application, Dornier's quoted price for a maintenance contract was $87,000 for the first year and $125,000 for each subsequent year as per December 1985 (Appendix III, OTA - p. 47). Using a five year life, this yields a December 1985 average of $117,400. While the application inflated the December 1985 amount to July 1, 1986. Mr. Heiden of Dornier Medical Systems indicated that those same rates exist today (August 7). The recommended August 1, 1986 maintenance amount is $117,400.

2. Personnel

Personnel estimates range from $87,085 at ProPAC to $161,301 at IHPA. The rate application notes OTA reported that salary costs, including fringe benefits and excluding physicians, were estimated at $131,000 and $130,000 respectively by AHA and Blue Cross. While that was OTA's report, the actual AHA data differed. The staff recommends the actual AHA estimate which appears to possibly be generous but is reasonable. That amount is $116,250 as of July 1, 1984. Price leveled to August 1, 1986 that becomes $124,900.

3. Insurance and Office Related Expenses

The application reflects the OTA report of Blue Cross and AHA studies. The cost of $75,000 for insurance and $28,000 for office related expenses appears appropriate. Price leveled from August 1, 1986 this gives $114,500.

4. Supplies

As the application notes, both the AHA and Blue Cross estimated the cost of medical supplies at $30 per patient examination. Price leveled from July 1, 1984 to August 1, 1986 the supply amount is $33.35 per patient examination.

5. Electrodes

The cost of electrodes is a significant part of the price of ESWL. The cost of electrodes per examination was estimated at $300 by both AHA and Blue Cross. This estimate was based upon a price per electrode of $200 and an average of 1.5 electrodes per examination. The OTA estimates, as noted in the rate application, that approximately two electrodes are used per patient. Neither ProPAC nor IHPA specify an estimate of electrodes per examination.

According to Mr. Heiden, Dornier currently sells electrodes at $180 each if more than 1,000 are bought per year. The electrodes currently approved by FDA are rated at 700 shocks. Dornier expects to shortly have approval for an electrode that delivers 1,100 shocks. He noted that a 2,000 shock electrode is expected after that.

The staff has been impressed with literature suggesting that as experience is gained with ESWL, patients requiring more shocks will be treated. For this reason the staff ~~believes~~ the August 1, 1986 cost should reflect two electrodes per procedure at a cost of $180 per electrode.

C. Indirect Cost

While the rate application did not request indirect cost, the Commission's staff believes some estimate of indirect cost is appropriate. We are recommending 40% of non-capital costs exclusive of electrodes and supplies. The August 1, 1986 amount is $139,800.

II. Volume

As can be seen from the pro-forma budgets presented in Appendix III, all costs other than supplies and electrodes are treated as fixed. Thus, cost per examination is greatly affected by the volume of patient examinations. The volumes used in the pro-formas range from 800 (AHA low) to 2,000 (Blue Cross high). We note particularly the OTA statement regarding volume:

> "Similarly, an appropriate caseload for an ESWL center has been assumed to be as low as 800 patients treated per year and as high as 2,000 patients. (The first figure is actually quite low, and the latter is by no means a practical maximum; a few hospitals are already serving 2,000 or more patients per year). (p. 50)."

In addition, the staff notes that all these volume numbers are based upon one shift - i.e., a forty hour week. There is no reason to believe the machine could not be used more if the demand were there.

Under these circumstances, the staff believes the lowest possible volume is ProPAC's estimate of 1200 patient examinations for an efficiently run lithotripter. If average treatment time is one hour as reported, then this represents less than 60% of "capacity". Given the clear ability to exceed this volume, the staff does not recommend any lower volume be used during the first year. In effect, 1,200 can be interpreted as a conservative measure of efficient use over the five year life of the machines.

III. Price Standard

Capital cost	$422,000
Maintenance	117,400
Personnel	124,900
Insurance and Office Related Expenses	114,500
Supplies (1200 at $33.35)	40,000
Electrodes (1200 at $360)	432,000
Indirect cost	142,700
	$1,393,500

-(422,000) + 512,100
1,483,600

Thus, the price standard would be $1,161.25 inflated from August 1, 1986 to the mid-year of the rate year and the hospital's mark-up would be applied. For AMI P.G. AMI Doctors' Hospital, this yields a rate of $1,291.85.

While the staff believes this is a very fair rate standard, the staff recommends an exception in the case of AMI P.G. Doctors' because of the nature of their financing and their different treatment under the tax laws. Thus, we recommend that their approved capital cost be $512,100 rather than $422,000. This brings total reasonable cost at 1,200 patients examinations to $1,483,600 at August 1, 1986. After inflation and mark-up, this results in a price per patient examination of $1,375.40. Until such time as a new price standard is appropriate (such as FDA approval of a much less costly lithotripter) or the Commission adopts a different price standard, future staff recommendations will be in accordance with the price standards identified in this review.

?

IV. Conditions:

The staff proposes that ESWL rates be 100% variable in line with a price standard and ESWL rates will be subject to inflation but would not be rate realigned until a hospital's rate review system includes a full year's data for the second time. (These were also applied in the MRI standard and requested in this rate application).

In considering whether ESWL should meet the Commission's policy regarding services which are 75% or more private ambulatory, we note that the OTA reports that free-standing ESWL facilities have avoided "hospitalization for the great majority of their patients" (p. 49) citing one example which treated patients from 14 - 77 years old from which only 12.1% were admitted, or 87.9% were ambulatory. While we have been advised that the current protocol at the Maryland Kidney Stone Center is to admit Medicare patients pre-lithotripsy, and other patients post-lithotripsy we believe experience with the machine will demonstrate that P.G. Doctors' claim that less than 25% of their patients will require admissions is a medically reasonable position. ✓ We are aware, however, that Medicare has ruled ESWL to be a covered service only on an inpatient basis. This may result in Medicare admissions for financial purposes. AMI P.G. Doctors' licensing application (Appendix IV) predicted 38.7% of their lithotripsy services to be to Medicare patients. Should experience prove the 75% standard was not met, we recommend a prospective (only) adjustment in the treatment of ESWL services relative to the new service dollars. The staff notes that only 7.8% of the discharges from AMI P.G. Doctors' in the four kidney stone DRGs last year were Medicare patients while the statewide percentage was 18.7.

The rate application (p. 11) seems to suggest that ESWL services should be treated as private ambulatory services even for patients who are subsequently admitted to the hospital. This is somewhat like a hospital declaring its labor and delivery room to be an ambulatory birthing center with admission occurring following delivery. The HSCRC law follows Medicare which defines all services provided at the same hospital within 24 hours of admission to be inpatient services. Thus, all ESWL services provided to patients who are admitted to P.G. Doctors' within 24 hours of the service are to be reported and charged as inpatient services.

The staff recognizes that both ProPAC and HCFA have recommended that all patients receiving inpatient Lithotripsy services be assigned to DRG 323. Since these recommendations applied only to Medicare, and, as noted above Medicare has currently deemed ESWL to be a covered service only on an inpatient basis, this assignment change will affect all Medicare patients covered for lithotripsy services. Since ESWL, unlike MRI, will, in some instances - i.e., patients under 70 without complications or comorbidities - result in assignment to a higher weighted DRG, it may also result in P.G. Doctors' attaining higher approved inpatient revenue under its current GIR agreement.

The staff notes that assignment of ESWL patients to the Medical DRG for urinary stones recognizes that savings associated with this new technology should not be measured relative to surgical removal. We believe the Commission should be wary of arguments for ESWL rates higher than those recommended because "the rates are still less than it would cost to treat the patients surgically". The staff would argue that such logic would result in transcontinental airline fares to be slightly less than the cost (in both time and direct expenses) of driving. The reasonable rate of a replacement technology should be measured independently and not in terms of the previous technology.

Given the above considerations, the staff is recommending the following additional conditions: that hospitals on the GIR get no price leveling factor adjustment for ESWL, that GIR hospitals finance ESWL charges for registered emergency and clinic patients from their 1% and that the 1% not be added for private ambulatory EWSL patients in accordance with the Commission's policy regarding services which are more than 75% private ambulatory. Patients who are inpatients of another hospital or referred directly from the emergency room or clinic of another hospital shall be considered private ambulatory patients at the ESWL hospital. (All these conditions were also part of the MRI standard.)

AMERICAN ACADEMY OF NEUROLOGY

STATEMENT OF THE AMERICAN ACADEMY OF NEUROLOGY
TO THE SUBCOMMITTEE ON HEALTH AND SUBCOMMITTEE ON OVERSIGHT
COMMITTEE ON WAYS AND MEANS, US HOUSE OF REPRESENTATIVES
ON SELF REFERRAL PRACTICES AND PHYSICIAN OWNERSHIP
FOR THE RECORD OF THE HEARING
OCTOBER 17, 1991

The American Academy of Neurology (AAN/Academy) is pleased to provide the Ways and Means Subcommittees on Health and Oversight with a statement for the record of the hearing October 17, 1991 on physician ownership and self-referral practices.

AAN is the country's largest organization of neurologists and neuroscientists with over 11,000 members. As neurologists, we treat many Medicare beneficiaries, and therefore are greatly concerned with any Medicare restrictions which would interfere with the provision of clinically and ethically sound medical care.

The Academy is deeply troubled by any occurrence of unethical medical practices by our physician colleagues in ownership and referral arrangements, and we commend Congressmen Stark and Pickle for addressing this issue. We believe, however, that such unethical practices are far less prevalent than reports or the media imply, and that any blanket ban on physician referrals to entities in which the physician has an ownership interest would cause an adverse effect on the quality of and access to medical care. Instead, the Academy recommends an approach that emphasizes: (1) identifying and sanctioning unethical and abusive medical practices through vigilant enforcement of the existing antikickback statute; (2) the restructuring of existing arrangements to minimize potential conflicts of interest, based on the recently released safe harbor rules and the opinions of the Ethical and Judicial Affairs Council of the American Medical Association (AMA); (3) greater vigilance by the medical profession on recognizing and disciplining physicians who violate professional codes of ethics; (4) maintaining a role for ethical and legitimate physician practices that contribute to the accessibility of technology, and delivery of high quality health care; and (5) determining whether further legislation is needed based on an objective monitoring and assessment over the next twelve to twenty-four months of how physicians and the health care industry respond to such changes as the promulgation of the safe harbor rules and the AMA's and the AAN's increased emphasis on disciplining physicians who violate the profession's ethical standards.

Self-Referral: An Integral Aspect of Medical Practice

As a vital aspect of their medical practice, many of our members are involved in providing imaging services, neurophysiology and other laboratory services to their patients, and have developed joint ventures to finance these important and needed entities. All of these services are best provided by neurologists because of their unique knowledge, training, and experience. It is critical to understand that legitimate self-referral is an inherent feature of modern medical practice for many specialties. For example, a family physician may prescribe and then perform a cholesterol test in his or her own in-office lab (a self-referral); or a cardiologist may prescribe an EKG and then perform the test in his or her own office (a self-referral); or a neurologist may prescribe an MRI scan and suggest that it be performed at a lab where the neurologist shares ownership. Obviously, should the costs of MRI equipment be such that it would lend itself to being purchased by individual neurologists' offices, the need for joint ventures would be eliminated. But, this is not the case.

The nature of self-referral in our health care system is as basic as a physician asking a patient to return for a follow-up visit, or a surgeon recommending and then performing an operation. These self-referral patterns are as ethical as a neurologist in private practice conducting doppler studies to measure blood flow, or electroencephalograms to measure brain activity, or an MRI test to diagnose multiple sclerosis (when such tests are deemed medically necessary). Self-referrals are an essential step in diagnosing and treating patient health care needs; and, in and of themselves, often represent a very necessary service to the patient.

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Evolution of Diagnostic Imaging Technology

To understand the critical role that recent diagnostic imaging technology plays in a modern neurology practice and its relation to referral practices, one needs only to trace the events of the past twenty years during which the evolution of this breakthrough technology took place. In the 1970s, new imaging technology made their first appearance in hospitals in the form of CAT scanners (CTs), and later in the 1980s by the introduction of Magnetic Resonance Imaging (MRI) scanners. Many neurology practices found themselves with limited or no access to these new technologies. Although access to hospital CTs by neurologists seemed to improve over time in some areas, the demand placed on medical center equipment by physicians in many specialties overwhelmed the available services. At this time, CT was clearly established as the preferred technology in detecting and evaluating many neurologic problems. Neurologists in private practice who found themselves without sufficient access to CTs to diagnose and treat their patients, thus, through group efforts, brought CT scanners into their offices.

In the mid-1980s, this history was repeated with MRI scanners. However, given that MRIs were then priced at $1.5 to $2.5 million, the most viable method to purchase these expensive pieces of equipment was to create joint venture partnerships among solo and group practices, usually with other neurologists, but frequently with neurosurgeons, radiologists, and other medical specialists. Initially, neurologists and other physicians who wished to introduce CTs and later MRIs into their communities found financial institutions and the general public unwilling to make the financial commitment necessary to support these new technologies, leaving physicians as the only source of capital -- a circumstance which still exists today. Nevertheless, neurologists who wanted to bring CT scanners into their offices, and later those who sought to develop MRI facilities made the decision that access to these technologies was vitally important for patient care and that those scanners needed to be part of or an extension of their practices. As to the ongoing proliferation in MRI technology, a recent study published in the September 1991 edition of the American Journal of Roentgenology suggests that the demand for MRI services is currently being met, implying a leveling off in the growth of these joint venture arrangements.[1] This is not to suggest, however, that the imaging marketplace has become static. Rather, as new applications for these technologies develop, and given the historical perspective, the imaging marketplace should be viewed in terms of being dynamic, ongoing, and evolutionary.

The Draft Florida Study

Florida's Health Care Cost Containment Board's draft study on Joint Ventures Among Health Care Providers, Volume II, released this August, provides an extremely limited study on the prevalence, scope, and nature of joint ventures among health care providers, and the impact of such ventures on access, utilization, costs, charges, and quality of health care services in the state of Florida. First, and foremost, the report fails to address the issue of appropriateness and necessity of care. The essential question is not one of physician ownership in joint ventures, but one of appropriate care and utilization of services and referral regardless of ownership. The Florida report looked only at the differences in utilization rates between joint ventures and non-joint venture entities, and did not evaluate, nor explain whether these differences were justified on a clinical basis. Implying that utilization differences alone equates with inappropriate or unnecessary medical care is simply not justified.

Second, the findings on the effect of joint ventures on the provision of services by diagnostic imaging centers are clearly not reliable because nearly all of the centers in Florida had joint venture ownership, making comparison with non-joint venture firms in Florida impossible; and although the authors attempted to compare the Florida joint venture data with data collected from non-joint ventures in Baltimore, many differences between the two areas, such as the size of the Medicare population, were not controlled for in any scientific way, while other differences such as health status were ignored completely.

Third, the report omits the important fact that physicians whose specialties require the use of specialty specific diagnostic testing modalities, e.g., neurology/neurosurgery with x-ray CT/MRI, tend to invest in facilities that perform these tests; and that those facilities would naturally experience utilization rates typical of neurologists and neurosurgeons, and display characteristics that differ from other centers with different specialty mixes. Again, it cannot be implied that such tests were inappropriate or medically unnecessary. It is not surprising then that physicians are inclined to invest in technology that they rely on in an effort to assure high quality care and to make such services readily available and accessible to their patients.

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[1] "Analysis of Economics and Use of MR Imaging Units in the United States in 1990," by Evens, and Evens, Jr., American Journal of Roentgenology (September 1991), pages 603-607.

Fourth, the indicators used to measure access and quality in the study are both flawed and of unproven validity.[2] In addition, while access to and quality of care are admittedly difficult to measure, more important questions such as whether Americans would be able to enjoy the same level of access if physicians were not permitted to invest or whether technology would be introduced or disseminated in a timely manner, need to be addressed.

Where to Go From Here: Observations and Recommendations

1. With publication of the safe harbor rules, the regulatory environment is now far different than it has been in the past. Therefore, to the extent that there are some studies (the designs and results of which are questionable) claiming to show overutilization associated with ownership, those studies cannot predict what will occur in the future now that the safe harbor rules have been promulgated. The safe harbor rules will undoubtedly generate a major restructuring of joint venture arrangements – and such restructuring may reduce the perceived association between ownership and overutilization, by eliminating those arrangements most likely to result in abuse. Studies a year or so from now may come to very different conclusions than earlier pre-safe harbor studies. In our view, it is only prudent for Congress to wait and see what happens, and to base further policy on an evaluation of the imaging environment, after the industry restructures under the safe harbor rules, before assuming that further limits are required. If it turns out those rules eliminate abusive practices – and give regulators sufficient authority to sanction those few instances where abuses take place, or that additional well designed studies show the absence of abusive practices – there will not be a need for further restrictions that may prove harmful.

2. The American Medical Association (AMA) has recently embarked on an aggressive campaign to eliminate unacceptable conflicts of interest through its Council on Ethical and Judicial Affairs, and the Academy strongly supports these efforts. The Council's activities include educating physicians of their ethical responsibilities regarding self referral and setting up an enforcement program to require compliance with the code of ethics. Along with this, the AAN looks forward to participating with the AMA in their new enforcement efforts. The Academy follows the AMA's code of ethics as it relates to self referral, and is in the process of developing a stronger mechanism for disciplining Academy members who engage in unethical and illegal conduct. The AMA guidelines include:[3]

    (1) the physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization;

    (2) the physician may not exploit the patient in any way, as by inappropriate or unnecessary utilization;

    (3) the physician's activities must be in strict conformance with the law;

    (4) the patient should have the free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere; and

    (5) when a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient.

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[2] See "Comments on: Joint Ventures Among Health Care Providers in Florida," Center for Health Policy Research, American Medical Association, Chicago, IL (August 1991); and Florida Medical Association Memorandum to the Health Care Cost Containment Board Joint Venture Technical Advisory Panel (August 15, 1991).

[3] 1989 Current Opinions, Council on Ethical and Judicial Affairs, American Medical Association, page 30.

In addition to the benefits of an outright enforcement mechanism, the AMA's activities in this area will cause physicians to reexamine those arrangements that may expose patients to inappropriate conflicts of interest. With greater vigilance by the AMA and others in the profession, the opportunity for abuse will be greatly diminished.

3. Implementation of the self-referral ban on physician ownership and referral to clinical laboratories enacted as part of OBRA '89 will provide a test case of the effects of such a ban, and will serve as a comparison to the safe harbor approach (which covers everything else). Congress should wait and see if the ban on clinical lab ownership adversely affects access, convenience and quality before expanding it to other facilities -- especially since the need for more restrictions is questionable given the safe harbors regulations.

4. Further studies should be conducted on the relationship between physician ownership and utilization. The results from the GAO study comparing utilization experiences of referring physician owned and other entities mandated in OBRA '89 and based on data currently being collected by the Health Care Financing Administration (HCFA) may shed more light on the issue. However, the value of this study may be limited since it will be an analysis of the past relationship between physician ownership and utilization, i.e., based on arrangements as they existed prior to the safe harbor rules and the medical profession's increased emphasis on disciplining physicians who engage in unethical practices. Consequently, further studies on the relationship between ownership and utilization following the restructuring that is likely to occur in the next several months is in order. Congress should certainly wait to benefit from such studies before any decisions on further bans of physician ownership and referral to entities are considered.

5. Most of the studies on physician facility ownership and utilization rates to-date have been flawed, in that they suggest that ownership causes overutilization, when higher and differing patterns of utilization may be due to other factors. For example, physicians whose patients require more diagnostic testing because of their medical conditions may be more inclined to enter into ownership as a convenience/quality control device for the patient; or physicians whose specialties demand that they use more diagnostic tests are likely to invest in facilities that perform them, causing utilization rates at these facilities to appear higher. The studies have also ignored the benefits of such arrangements to patients.

Patients can often be better served by a neurologist's direct involvement in imaging centers for a variety of reasons depending on the circumstances in the community. If the only MRI service in the community is from a hospital or corporate facility, especially if there is a monopoly -- poor service, higher charges, less convenience, longer waits by patients, longer waits for results to get back to the referring physician, etc., will likely result; in contrast to communities where physicians have set up more convenient, patient and service focused entities. For example, the quality of the testing may be better in physician owned imaging centers because physician owners often assure that there is a "hands-on," on-site physician, usually a neurologist or neuro-radiologist to monitor the course of the exam and the images, and modify the study as appropriate should the initial standard images show abnormalities requiring additional study through other types of imaging techniques. As patient conditions differ, the physician needs to determine in an ongoing manner during the course of the exam the types of studies and "slicing" required -- which technologists cannot determine. In fact, when technologists perform this role, as is the case in most hospital based facilities (where a radiologist may read the scans only at the end of each day), the test initiated may prove to be inadequate for diagnosis and require that the study be repeated with different and additional techniques, hence increasing the cost of care, delaying the diagnosis, and causing the patient the inconvenience of returning to the lab for testing which could have been performed during the first visit. It cannot be stressed enough that the active participation of the clinician (either a neurologist or neuro-radiologist) in the decision-making process regarding the design and performance of the examination is essential to obtain an optimal study and a specific diagnosis. The presence of a physician in the delivery of care, including performing and reading imaging tests ensures the most efficient, economical, and the highest quality care for the patient.

In many cases, hospital based imaging labs also will not perform more detailed or complex imaging procedures, even if the ordering physician requests them, because they take longer to perform, tying up the hospital's equipment, and because the reimbursement is the same regardless of whether it is for a standard vs. a more complex exam. Contributing to a more accurate diagnosis, the more complex exam is clinically indicated in many cases; and physician owned facilities ensure that when the ordering physician calls for them they are performed, regardless of the lesser reimbursement level.

On the access issue, many neurologists, as noted above, were instrumental in introducing advanced imaging services into their communities, even before Medicare and Medicaid reimbursed for them, because they wanted to provide their patients with the highest quality care. Numerous physician owned imaging facilities provided then, and continue to provide services regardless of whether the patient has the ability to pay. Private, non-physician owned imaging centers would not be (and are not) concerned with this needed access, nor are they inclined to provide the best service, or highest quality of care. Rather, they are only interested in the facility's bottom line.

Closing

The American Academy of Neurology is sincerely concerned about fraudulent, abusive and unethical medical practices, and supports every effort to end them without disturbing legitimate and ethical practices which make access to services more available and of better quality. Although there have been abuses in the past, given the safe harbor rules, vigorous enforcement of the Medicare antikickback fraud and abuse statute of the Social Security Act, and greater vigilance by AMA and others in the profession, the Academy strongly believes that the opportunity for abuse will be greatly diminished. Blanket prohibitions may not be necessary, and in fact may reduce access to services that provide better, higher quality, and more convenient services for patients. It is reasonable for Congress to wait and see what happens given these changes, and then consider, after careful evaluation, whether or not further restrictions are advisable.

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AIA
American Imaging
Association

TESTIMONY BEFORE THE HOUSE WAYS & MEANS COMMITTEE
SUBCOMMITTEE ON HEALTH
SUBCOMMITTEE ON OVERSIGHT
HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS
OCTOBER 17, 1991

WAYNE L. WAMPLER, PRESIDENT

As President of the American Imaging Association ("AIA"), I am pleased to have the opportunity to submit this testimony concerning physician ownership and referral arrangements, in conjunction with the hearing held on this subject by the Subcommittee on Health and the Subcommittee on Oversight of the Committee on the Ways & Means. AIA is a trade association representing over 175 outpatient imaging centers, mobile diagnostic services, and associated physicians and other professionals in 32 states. AIA and its members are dedicated to the conduct of high quality, cost-effective diagnostic imaging services throughout the country. While AIA strongly supports efforts to curb fraud and abuse in the health care marketplace, AIA believes that diagnostic imaging centers should continue to have access to physician capital, and that Congress should refrain from imposing additional limitations on physician investment in health care facilities at this time.

I. PHYSICIAN INVESTMENT IN DIAGNOSTIC IMAGING CENTERS: BACKGROUND

Numerous factors have contributed to physician investment in outpatient imaging centers. Physician investment in imaging centers has evolved as a natural response to the demand for improved services, the unavailability of alternative sources of traditional financing, and, burdensome state regulatory requirements, and has had the beneficial effect of making state-of-the-art technology readily available in communities throughout the country.

The primary impetus for physician investment in the outpatient imaging industry was the desire to improve access to and quality of outpatient services at competitive prices. Private referring physicians were dissatisfied with the inability (or, in some cases, the unwillingness) of hospitals to deliver outpatient imaging services in a convenient, timely and cost-effective manner. Hospitals were reluctant to purchase, or by virtue of state CON requirements were precluded from acquiring, costly magnetic resonance imaging (MRI), computerized tomography (CT), ultrasound and other state-of-the-art technologies. Where the technologies existed, physicians and their patients often encountered scheduling conflict in acute care hospitals because of inpatient utilization of equipment. In addition, in the hospital setting, outpatients in need of imaging services were often co-mingled with inpatients with more serious illnesses. In short, in many areas, outpatient imaging services were unavailable or unacceptable. Even today, hospitals in smaller communities lack the capital to upgrade imaging services and rely on physician-hospital ventures to provide the highest quality diagnostic care.

The imaging industry brought together business people who recognized the obvious need for freestanding outpatient diagnostic services and physicians determined to provide such services for their patients. At least initially, imaging center developers found financial institutions and the general public unwilling to make a financial commitment to support such new, innovative, and capital intensive approaches to health care delivery.

Lenders were often unwilling to provide the necessary capital for the establishment of diagnostic imaging centers for a number of reasons. First, in the early 1980s, the health care environment was becoming increasingly competitive, and many lenders believed that new start-up ventures could be easily undermined by existing hospitals and other health care institutions. Second, a free-standing imaging center was looked upon by lenders as a "special purpose facility" due to extensive leasehold improvements required for facility operation. By definition, the lender viewed this type of facility as "high risk" due to the high cost per square foot and limited alternative use in the event the project failed. Third, the nature of the equipment necessary for the development of an imaging center is likewise highly specialized, and the residual value of such equipment is minimal due to rapidly changing technology. Thus, for a number of reasons, developers of imaging centers historically found access to conventional sources of capital extremely limited. Under these circumstances, in many instances, physicians were the only, or at least primary, sources of capital available for the development of freestanding imaging centers.

II. THE DEBATE CONCERNING PHYSICIAN INVESTMENT: DEVELOPMENTS SINCE 1989

Thus far, the debate on physician ownership of health care facilities has generated far more heat than light. How vividly AIA recalls the debate on this issue in 1989. The year began with the introduction of the "Ethics in Patient Referrals Act of 1989" -- broad, sweeping legislation that would have precluded physician investment in virtually any health care facility. The year ended with the enactment of extremely limited legislation affecting only physician ownership of and compensation arrangements with entities providing clinical laboratory services. After long and hard deliberation, Congress concluded that there was no evidence of abuse with respect to physician investment in diagnostic imaging centers or any other kind of health care facility. Congress also concluded that additional information was needed concerning the impact of physician ownership on the cost, quality, and utilization of health care services. To obtain such information, Congress mandated that the Health Care Financing Administration collect data concerning the impact of physician ownership on health care facilities' utilization, costs, and quality and that the General Accounting Office conduct an independent study of this issue. To date, neither of these studies have been issued.

AIA respectfully submits that nothing has transpired to warrant a reexamination of this issue at this time. To the contrary, today there is even less reason for legislation in this area then there was in 1989. In 1989, there was little enforcement of the anti-kickback provisions of the Medicare and Medicaid anti-fraud and abuse laws. The only penalties then available to law enforcement officials were criminal penalties which were rarely enforced. Since 1989, the Office of the Inspector General ("OIG") has begun to enforce the anti-kickback provisions through civil sanctions. Extremely narrow "safe harbor" regulations have been issued under which almost all joint ventures are subject to scrutiny, and, today, abusive joint ventures and their physician investors can be excluded from participation in the Medicare and Medicaid programs without a prior judicial hearing. In fact, the OIG has recently brought its first action to exclude a joint venture from the Medicare and Medicaid programs for violating the anti-kickback provisions. Under the precedent established by that case, a joint venture may be excluded from participation in federal programs if it pays "anything of value, in any manner of form, with the intent of exercising influence over a physician's reason or judgement..." While the precise impact of the safe harbors and of more aggressive enforcement of the anti-kickback provisions is not yet clear, AIA believes that these developments will have a significant effect on the extent and nature of physician investment. For this reason, it would clearly be premature to impose additional restrictions on physician investment at this time, before the impact of these major changes can be determined.

Moreover, since 1989, both Congress and the Health Care Financing Administration have become aware of the difficulties involved in the adoption of broad legislative proscriptions on physician ownership. The 1989 self-referral legislation has already been amended once, and it is proving difficult for the Health Care Financing Administration to draft proposed regulations without affecting physician's office facilities. This experience strongly suggests that it is extremely difficult to draft legislation and regulations on this issue without "throwing the baby out with the bathwater," and that it is best to deal with abusive arrangements on a case-by-case basis, through the vigorous enforcement of current law.

In addition, since 1989, the Federal Trade Commission ("FTC") -- an agency whose primary goal is to foster competition -- has indicated that restrictions on physician ownership arrangements could adversely impact competition in the health care industry. More specifically, in an April 10, 1990 letter to Senator John Heinz, the FTC cautions that before extending physician ownership restrictions to additional ancillary services, the impact of current restrictions on clinical laboratory services should be studied. The FTC concludes that, in light of the cost savings, high quality, and greater convenience that may result from physician ownership, "prohibitions on referral [should] be narrowly crafted to address only instances in which there is evidence of demonstrable harm."

Why, then, reopen the issues now, before the results of the HCFA and GAO studies are available? The answer appears to be the issuance of a draft report by the Florida Health Care Cost Containment Board entitled "Joint Ventures Among Health Care Providers in Florida, Vol. II," (hereafter the "Florida Study"). The Florida study has received considerable publicity for its conclusions that diagnostic imaging center joint ventures result in increased utilization and exorbitant profits.

III. THE FLORIDA STUDY: AN ANALYSIS

AIA requested Lewin/ICF, a well-respected health care consulting firm, to review the Florida study's conclusions regarding the impact of physician ownership on utilization, costs and access in the diagnostic imaging industry. This analysis, "The Effects of Joint Venture Ownership of Imaging Centers by Physicians: An Appraisal of the Florida Health Care Cost Containment Board Report," (Hereafter the "Lewin/ICF analysis") has been made available to Committee staff. The Lewin/ICF analysis establishes that:

- The Florida study does not justify the conclusion that physician ownership increases utilization;
- The Florida study does not establish that diagnostic imaging center joint ventures are more costly or more profitable than non-joint venture diagnostic imaging facilities, nor does it attempt to do so. Moreover, the Florida study ignores capital an other indirect costs in analyzing profitability, thus overstating the profitability of highly capital intensive facilities, such as diagnostic imaging centers.
- The Florida study's findings, properly interpreted, suggest that physician ownership **does** improve access to diagnostic imaging services.

A number of preliminary observations concerning the context of the Florida study are in order. The Florida study was mandated by the Florida legislature. The researchers' mission was to examine the impact of physician investment on the utilization of, costs of, and access to various health care services. The researchers took a "snapshot" approach to this task, relying primarily on 1989 data as the basis of their study. Unfortunately, however, the study lacks an historical perspective concerning the reasons for the growth on physician ownership in diagnostic imaging centers, as set forth the above.

Moreover, in Florida, another factor contributed substantially to the reliance on physician capital. Specifically, in Florida, hospitals have historically been subject to onerous certificate of need ("CON") requirements for the establishment of new health care services; physicians offices generally have been exempt from these requirements. For this reason, it is hardly surprising that virtually all of the outpatient diagnostic imaging centers in Florida are structured as freestanding "physicians office" facilities, rather than as hospital-based facilities. Thus, any implication that the significant physician investment in the imaging center industry in Florida developed solely as a means of paying physicians in exchange for referrals is unfounded. Because the Florida study fails to provide an historical perspective on physician investment, it overlooks the fact that physician investment made high quality diagnostic imaging services available to the citizens of Florida efficiently and expeditiously.

As the Lewin/ICF analyses observes, the Florida study also has a number of significant methodological flaws. The specific findings of the Lewin/ICF analysis are set forth below.

I. The Florida Study Does Not Support The Conclusion That Physician Ownership of Diagnostic Imaging Centers Increases Utilization.

The Florida study attempts to determine whether physician ownership affects the utilization rates of MRI and CT scanning by comparing the 1989 utilization rates of MRI and CT in three Florida MSAs where physician ownership was common (Miami, Orlando, and Jacksonville) with the 1989 utilization rates for these services in the Baltimore MSA, where physician ownership was uncommon. Because utilization of MRI and CT was somewhat lower in the Baltimore MSA than in the three Florida MSAs, the Florida study concludes that physician ownership results in increased utilization. The Lewin/ICF analysis, however, establishes that data in the Florida study do not justify this conclusion.

First, the Florida study does not suggest or imply that the marginally higher utilization of diagnostic imaging services provided in the Florida MSAs was inappropriate. Lewin/ICF analysis at 4. In fact there is substantial evidence that the difference in utilization between the Florida MSAs and the Baltimore MSA was due to a relative shortage of diagnostic imaging facilities in Baltimore during the period covered by the study. Lewin/ICF analysis at 6-7. More specifically, as the Lewin/ICF analysis indicates, there were 22 freestanding and hospital-based MRI scanners in the five county Baltimore MSA as of June 1991. This is nearly triple the census of scanners at the conclusion of 1989, the period covered by the Florida study. Indeed, if the new MRI scanners in Baltimore are utilized at the same rate as those that existed in 1989, utilization rates in Baltimore would be **higher** than those in Florida. Lewin/ICF analysis at 6-7. Thus, AIA respectfully submits that the Florida study findings simply suggest that the diffusion of diagnostic imaging technology in the Baltimore area was slower than the diffusion of this technology into various MSAs in Florida; these findings provide no basis whatsoever for concluding that physician ownership in diagnostic imaging centers causes increased utilization.

Second, while differences in utilization were found between the Baltimore MSA and the Florida MSAs (and among each of the Florida MSAs), and while some of these differences appear to be statistically significant (i.e. the utilization difference between Jacksonville and Miami) the authors do not indicate that the utilization differences between the Baltimore MSA and each of the Florida MSAs meet the test of statistical significance established for the study. Lewin/ICF analysis at 5.

Third, in estimating the utilization rate of diagnostic imaging services in the Florida MSAs, the authors of the study excluded "snowbirds" -- seasonal residents of Florida who list their permanent place of residence in other states. Lewin/ICF concludes that the exclusion of this population data likely inflated the utilization rates for the Florida MSAs. Lewin/ICF analysis at 6. Lewin/ICF also concludes that the seasonal in-migration of older retirees into Florida undermines the Florida study's conclusion that the Baltimore MSA is demographically comparable to the Florida MSAs studied. As the Lewin/ICF analysis observes, "snowbirds" tend to be older retirees, a group more likely to require diagnostic and other medical interventions. Id.

Fourth, there is no reason whatsoever to believe that the differences in utilization among the various MSAs analyzed were attributable to physician ownership. For example, the study reports that there were 1.7 fewer MRI scans per thousand population performed in Baltimore (where physician ownership was reportedly low) than were performed in Jacksonville (where physician ownership was reportedly high). This finding might be thought to be important, were it not for the fact that there were 5.7 more MRI scans performed per thousand population in Miami than there were in Jacksonville -- both of which are counties where physician ownership was high. Likewise, the difference in utilization between the Baltimore MSA and the Jacksonville MSA with respect to CT scans is much less striking than the difference in CT utilization between the Jacksonville MSA and Miami MSA. See Lewin/ICF analysis at 6. Under these circumstance, AIA believes that there is no basis whatsoever to conclude that physician ownership "caused" the higher utilization of diagnostic imaging services observed in the Florida MSAs in 1989.

II. The Florida Study Does Not Suggest Or Imply That The Charges of Diagnostic Imaging Center Joint Ventures Are Higher Than The Charges Of Non-Joint Venture Diagnostic Imaging Centers Nor Does The Florida Study Support The Conclusion That Diagnostic Imaging Centers Produce Exorbitant Profits.

The Florida Study reports that "joint venture imaging centers in Florida are far more profitable than most other non-joint venture Florida health businesses." This conclusion is based on a measure of profitability that essentially excludes a variety of indirect expenses, including interest expenses and other overhead. Lewin/ICF analysis at 7. Diagnostic imaging centers are extremely capital-intensive enterprises, compared with other kinds of health care facilities; it is hardly surprising, then, that diagnostic imaging center joint ventures appear more profitable than other types of health care enterprises, if capital and other overhead expenses are not considered! Lewin/ICF analysis at 7-8.

More importantly, as the Lewin/ICF analysis observes, it is essentially meaningless to compare the profitability of diagnostic imaging centers with the profitability of other health care facilities. The relevant comparison is between joint venture diagnostic imaging center and non-joint venture (hospital based) diagnostic imaging centers offering comparable services. Lewin/ICF analysis at 8. In this regard, AIA submits that joint venture diagnostic imaging centers, which are treated by the Medicare program as "physicians offices" are reimbursed significantly less than hospital-based facilities, which are reimbursed based, in part, on their actual costs. Significantly, too, the reimbursement for diagnostic imaging services rendered to Medicare patients has been reduced by approximately 28% since 1989, and further reductions in the range of 16-32% are currently under consideration. In short, diagnostic imaging center joint ventures are significantly less costly for the Medicare program and Medicare patients than comparable hospital alternatives.

III. The Florida Study Data Suggests The Physician Ownership Does Improve Access To Care.

The Florida study indicates that access to care can be measured based upon the availability of services to underinsured and indigent patients and on the geographic location of physician-owned facilities. Florida study at xiii. Significantly, the Florida study suggests that diagnostic imaging center joint ventures provide a significant volume of services to indigent, uninsured, and underinsured patients; specifically, while the report indicates the joint venture imaging centers do not provide a significant volume of services to Medicaid beneficiaries, the data indicates that 9.6% of revenues is lost to bad debt and charity care at MRI centers and 7.6% is lost to these causes at CT scanners. Lewin/ICF analysis at 9. As the Lewin/ICF analysis observes, these are significant amounts for businesses that lack a charitable mission. Id.

Moreover, the Florida data indicates that there are large areas of the state of Florida where the only available MRI services are provided through joint ventures. Lewin/ICF analysis at 8-9. In fact, if not for joint ventures, there would not be a single MRI in the panhandle of Florida. **Id.** Thus the Florida study actually indicates that joint ventures do provide access to services that otherwise would not be available.

In conclusion, AIA believes that more vigorous enforcement of the current anti-kickback provisions will help eliminate abusive self-referral arrangements from the health care marketplace. The Florida study does not support additional restrictions on physician investment at this time, and the results of the HCFA and GAO studies of the issue are not yet available. In light of the enormous disruption that such additional restrictions would cause for the provision of health care services throughout the country, AIA firmly believes that such restrictions should not be extended beyond the clinical laboratory arena at this time.

If the Subcommittees have any additional questions or need any further information concerning AIA's position regarding this most important matter, please contact AIA's Executive Vice President Joseph Thompson at (202) 296-9200.

The Effects of Joint Venture Ownership Of Imaging Centers by Physicians: An Appraisal of the Florida Health Care Cost Containment Board Report

October 7, 1991

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EXECUTIVE SUMMARY

The August 1991 draft report Joint Ventures Among Health Care Providers in Florida, Volume II is an ambitious examination of joint ventured health service provider organizations. In the report several conclusions were drawn regarding the effect of joint ventures on utilization, cost, and access to care provided by diagnostic imaging centers. The draft report has received considerable publicity for its findings of higher utilization and greater profitability of joint ventured MRI and CT scanners. Lewin/ICF was asked to review this report and assess the validity and meaningfulness of these conclusions. Our analysis calls these conclusions into question. Specifically we find:

- **Utilization** - data in the report do not justify the conclusion that observed differences in utilization are due to different ownership patterns among diagnostic imaging centers. There is reason to believe that the observed differences may reflect incorrect population data and regional variations in practice patterns. Even if the observed differences in utilization are correct, the study provides no evidence to suggest these differences are statistically meaningful.

- **Profitability** - The study lacks the data needed to compare the profitability of joint venture and non-joint venture imaging centers. Instead it compares the profitability of imaging centers to other types of medical service enterprises. This comparison is without meaning. Moreover, the study uses a questionable measure of profitability that overstates the "profits" of enterprises with high interest and other indirect expenses. This measure makes it virtually certain that capital intensive imaging centers will appear more "profitable" than the other ventures studied.

- **Access** - The study's conclusions that joint venture ownership do not improve access to care are incorrect. The study data indicate that large areas of the state of Florida are dependent upon joint venture imaging centers to provide MRI services. Second, there is no evidence to suggest that the apparent under-representation of Medicaid and uninsured patients in the imaging centers reflects joint venture ownership. The study lacks the data needed to determine whether physician-owned joint venture imaging centers provide more, less, or the same amount of charity care than other for-profit imaging centers.

I. INTRODUCTION

The August 1991 draft report, Joint Ventures Among Health Care Providers in Florida, Volume II, prepared for the Florida Health Care Cost Containment Board (HCCB) by Jean Mitchell, Ph.D. and Elton Scott, Ph.D., of Florida State University, has received extensive publicity in the media and significant consideration among state and federal decision makers. Much of the publicity and discussion of the report has focussed on the report's findings that:

- the 1989 utilization rates (tests/1000 population) for magnetic resource imaging (MRI) and computed tomography (CT) were considerably higher in the state of Florida, where virtually all scanners are established as joint ventures (JVs) with physician owners, than in the Baltimore area, where physician ownership was less prevalent.

- profitability appears higher for imaging centers that perform MRI and CT scanning than for non-JVs in other medical services.

- Medicaid and uninsured patients do not appear to have access to services in these imaging centers to the same extent as patients with other insurance coverage.

Lewin/ICF was asked to review the Florida report to determine whether these conclusions regarding JV imaging centers are justified. The focus of our review is on sections of the draft report pertaining to imaging centers, specifically centers that provide MRI and CT.

The HCCB study was an ambitious undertaking involving primary data collection from several thousand health service providers. The breadth of the study provides a rich data source on joint ventures in nine areas of medical service. Despite the authors' efforts, the structure of the Florida market limited the data available for analysis of the effects of physician ownership of diagnostic imagining centers. The authors made a concerted effort to overcome these data limitations and draw meaningful conclusions about the effect of JV's on utilizations, profitability, and access to care. Our review of the study raises questions about the appropriateness of the comparisons made and the validity of subsequent conclusions drawn in the study. For example, the HCCB report defines JVs as

> any ownership, investment interest, or compensation arrangement between physicians and any health care professional who makes referrals and an entity providing health care goods or services.[1]

This definition is overly broad since it includes facilities that are associated with a physician's own practice, hospitals, HMOs, and publicly-owned firms. We suggest alternative explanations for the study's findings; explanations that are more consistent with medical practice patterns and more recent information. In the sections that follow, each of the three areas in which the study drew conclusions -- utilization, profitability, and access -- are reviewed.

II. UTILIZATION

The HCCB study attempts to determine whether ownership patterns affect the utilization rates of MRI and CT scanning. We note at the outset that the study compares high and low utilization rates but does not attempt to distinguish between appropriate and inappropriate utilization. This is a critical distinction. A higher utilization rate is appropriate if it reflects use of available scanners to perform medically necessary tests that would otherwise be performed invasively or not at all. A lower utilization rate may be inappropriate and reflect the use of less desirable, more costly, and more invasive tests in lieu of a non-invasive scan.

The study defines utilization rates as tests/1000 population. The authors compare the utilization of MRI and CT in three Florida MSAs (Miami, Orlando, and Jacksonville) to utilization in the Baltimore MSA. Comparison to an area outside of Florida was necessary because:

- virtually all MRI scanners in Florida were JVs, making intra-state comparison between JV and non-JV of little value, and

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[1] HCCB draft report page iii.

- a comprehensive census of all CT scanners in Florida could not be developed because of a lack of central registry of scanners.[2]

The estimates of utilization (number of tests) in Florida were provided by each imaging center and are based upon their 1989 caseload. These estimates were summed and divided by the estimated 1989 population. These results were then compared to data from the Baltimore MSA. The reported results are summarized in Table 1. It should be noted that the authors do not indicate that these differences meet the test of statistical significance established for the study, although it appears that some of the differences would be significant (e.g., between Jacksonville and Miami).

TABLE 1

COMPARISON OF MRI SCAN AND CT SCAN UTILIZATION RATES

	1989 UTILIZATION RATES	
MSA	*MRI SCANS PER THOUSAND POPULATION*	*CT SCANS PER THOUSAND POPULATION*
Jacksonville	14.0	29.4
Miami	20.3	35.7
Orlando	16.6	31.9
Baltimore	12.3	27.9

Source — HCCB Draft Report, Table 4.9

There is reason to believe the comparison of utilization rates from the Baltimore and Florida MSAs is inappropriate due to inaccuracy in the Florida population data and recent data from Baltimore that suggest the 1989 MRI utilization rates were low due to an apparent shortage of scanners in that MSA.

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[2] Conversation with Dr. Jean Mitchell.

The Florida population estimates used in the study exclude seasonal residents ("snowbirds") who list their place of permanent residence in other states. This tends to understate the denominator in the utilization rate calculations. Although this is partially offset by individuals with dual residences who list Florida as their place of permanent residence (due to the absence of a state income tax), we believe the greater effect is due to non-resident snowbirds who are not included in the Florida census. This would mean the utilization rates for Florida are somewhat inflated. We attempted to adjust the utilization rates to reflect this seasonal population effect but, like the study's authors, found the data necessary to make this correction are unavailable.

The seasonal in-migration to Florida also undermines the validity of the Florida-Baltimore comparison. The study indicates the "reasonableness" of this comparison is based on census data suggesting similar demographic and income profiles in the three Florida MSA's and the Baltimore MSA. However, the seasonal migration is likely to eliminate this similarity since snowbirds tend to be older retirees, a group more likely to require diagnostic testing and other medical interventions. Even if these temporary residents could be accounted for in the population data, one would expect higher utilization rates among the older population in Florida.

Even if the census data were correct and the comparison to Baltimore were appropriate, there is no reason to suggest that JV's are responsible for observed differences in utilization rates. Regional variations in practice patterns have been documented for a broad range of medical procedures, and there is ample reason to believe these variations exist in the field of MRI and CT scanning. Indeed, such variations are seen within the state of Florida itself. The difference between the number of MRI scans/thousand in Jacksonville and Baltimore is much less striking than the difference between the number performed in Jacksonville and Miami. As was noted previously, higher utilization rates could reflect the appropriate use of a preferred diagnostic test while lower utilization rates could reflect the need to use less desirable diagnostic procedures due to lack of availability of the preferred testing modality.

Recent data suggest there was a relative shortage of MRI scanners in the Baltimore

MSA in 1989. This shortage would tend to have reduced 1989 utilization rates in Baltimore below optimal levels. A 1991 directory of imaging centers provided by the Office of Licensing and Certification Programs of the Maryland State Department of Health and Mental Hygiene indicates that there were 22 free-standing and hospital-based MRI scanners in the five county Baltimore MSA as of June 1991[3]. This is nearly triple the census of 8 scanners at the conclusion of 1989. This explosion in the number of scanners strongly suggests that the utilization rates in Baltimore were depressed, reflecting a significant shortage of MRI services during 1989. Indeed, if the new MRI scanners in Baltimore are utilized at the same rate as those that existed in 1989, utilization rates in Baltimore would be higher than those in Florida (an estimated 33.8 scans/1000 in Baltimore based on 1989 utilization rates and 1991 scanner census versus actual 1989 Florida utilization rates of 14.0, 16.6 and 20.3 in Jacksonville, Orlando and Miami, respectively).

III. PROFITABILITY

The HCCB study reports "joint venture imaging centers in Florida are far more profitable than most other types of non-joint venture Florida health businesses."[4] This conclusion is based on a profitability comparison that uses operating income as the measure of profitability. As defined in this study, operating income equals net revenues minus direct operating expenses. This definition excludes a variety of indirect expenses including interest expenses and other overhead.

This definition of profitability is quite different from the more traditional definition of profitability as revenues minus expenses. Although one can understand the desire to exclude depreciation and other non-cash expenses from the analysis, the exclusion of all indirect expenses systematically overstates profitability since it excludes interest and other indirect cash expenses. When making comparisons among different types of outpatient facilities, the chosen measure of profitability disproportionately overstates the profitability of imaging centers with MRI and CT scanners, since the interest costs related to debt service of these multimillion dollar machines are excluded from the analysis. Thus, it is not surprising to find JV imaging centers appear more profitable than other types of less capital-intensive enterprises.

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[3] Directory of Major Medical Equipment, Maryland State Department of Health and Mental Hygiene, Office of Licensing and Certification Programs, June 1991.

[4] HCCB Draft Report, page vi.

Even if the authors had been allowed the time and resources to develop a measure of profitability that could account for the complexity of financial arrangements in imaging centers and other JV enterprises, the comparison of the profitability of JV imaging centers to other types of ventures has little meaning. It may be the case that imaging centers are more profitable than other types of medical enterprises.[5] The relevant comparison of profitability is between JV imaging centers and non-JV imaging centers. Despite the authors' extensive data collections, the Florida market provides no data to allow for this comparison. It is impossible, therefore, to reach any conclusion from this study on the effect of JVs on the profitability of diagnostic imaging centers.

IV. ACCESS TO CARE

The HCCB report indicates that access to care can be measured on two criteria:

> Access is evaluated by examining the availability of services to insured, underinsured, and indigent patients. The geographic location of these facilities is also noted to ascertain whether joint ventures increase access to persons residing in medically underserved areas.[6]

The report concludes that JVs do not improve access to care. Yet the data in the HCCB report indicate that JV imaging centers are responsible for improved geographic access to imaging services in the state of Florida. Figure 1 presents the distribution of MRI centers by county and reflects the information provided in Table 4.6 of the report (Comparison of Outpatient MRI Scans Performed in Florida Counties with Joint Venture Diagnostic Imaging Centers, 1989). Figure 1 indicates there are large areas of the state of Florida where the only available MRI services are provided through joint ventures. This includes the entire panhandle region.

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[5] The greater profitability of imaging centers, especially those with MRI scanners, should come as no surprise. MRI scanners represent a relatively new technology with a high start-up cost. One would expect that as the technology matures and more centers open, the profitability will fall into the range of other mature medical technology services.

[6] HCCB draft report page xiii.

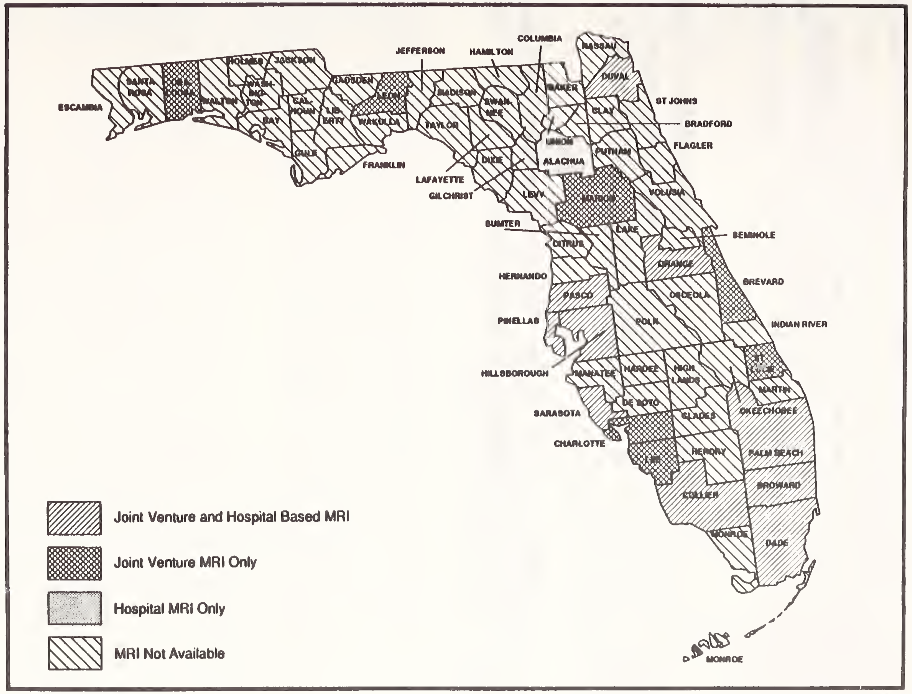
The data also indicate that JV centers provide services to indigent, uninsured and underinsured patients. Although the report indicates that JV imaging centers provide virtually no services to Medicaid beneficiaries, it shows that 9.6 percent of revenue is lost to bad debt and charity care at MRI centers and 7.6 percent is lost to these causes at CT centers. These are significant amounts for businesses that lack a charitable mission.

If an access problem does exist, it is most likely related to the non-eleemosynary nature of these ventures rather than the JV ownership. There is no evidence in the report to suggest that JV are more or less likely to provide care to patients unable to adequately pay for services than any other type of for-profit imaging center.

V. CONCLUSIONS

The HCCB report on the effects of JV ownership provides a considerable amount of important data to inform the debate on physician ownership of medical service facilities. Lewin/ICF's review of the study's conclusions in three areas -- utilization, profitability, and access -- raises questions about the appropriateness of the comparisons made and the validity of subsequent conclusions drawn in the study. First, the HCCB study compares utilization of MRI and CT in Florida and Baltimore to determine whether ownership patterns affect these rates. There is reason to believe, however, that this comparison is inappropriate due to inaccuracies in the Florida population data. In addition, recent data suggest that 1989 MRI utilization rates in Baltimore were low due to a shortage of scanners. Even if this comparison were appropriate, there is no evidence that JVs are responsible for differences in utilization rates, as regional variations in practice patterns have been documented for a variety of medical procedures. Finally, the study makes no attempt to determine if higher utilization rates are medically appropriate compared to lower rates.

Distribution of MRI Scanners in Florida, 1989



Source: HCCB, Table 4-6

Note: Alachua county was not reported as having an MRI Scanner in the report. However, one of the study's authors reports there was a hospital based scanner in the county in 1989.

The HCCB study reported that JV imaging centers in Florida are more profitable than other non-JV health businesses in the state. This conclusion is based on a comparison of operating incomes. However, the definition of operating incomes excludes a variety of indirect expenses including interest expenses and other overhead. This exclusion overstates the profitability of imaging centers with MRI and CT scanners, which are extremely capital-intensive.

Finally, the HCCB report concludes that JVs do not improve access to care. Yet JV imaging centers are responsible for improved geographic access to imaging services in Florida. In addition, data indicate that a significant percentage of revenue at JV imaging centers is lost to bad debt and charity care.

These alternative explanations for major findings of the HCCB report are indicative of the need for more research to determine the effects of JV ownership on utilization, access, quality, and cost of care in imaging centers.

35 Anniversary
[redacted] PPs
1956–1991
Private Practice Section
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STATEMENT OF THE AMERICAN PHYSICAL THERAPY ASSOCIATION, PRIVATE PRACTICE SECTION TO THE SUBCOMMITTEE ON HEALTH AND SUBCOMMITTEE ON OVERSIGHT COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES FOR THE RECORD OF THE OCTOBER 17, 1991 HEARING ON PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

The Private Practice Section ("PPS") of the American Physical Therapy Association ("APTA") is pleased to provide the Ways and Means Subcommittee on Health and the Subcommittee on Oversight with a statement for the record of the October 17, 1991 joint hearing on "Physician Ownership/Referral Arrangements." For the past 35 years, the Section has represented the professional interests of physical therapists in private practice. Today, the PPS provides a voice to over 5,000 private practitioners dedicated to furnishing the public with the highest quality, state-of-the-art physical therapy services available in the office and certain institutional settings.

The APTA and its Private Practice Section have long opposed physician referral for profit. In 1985, the APTA House of Delegates adopted the policy that "mere referral does not constitute a professional service for which a professional charge should be made or for which a fee may be ethically paid or received." The policy further states that "these arrangements offer a serious potential for abuse in the provision of physical therapy." That abuse -- together with its detrimental impact on the quality of physical therapy care -- has never been more obvious than it is today.

Volume II of the Florida Health Care Cost Containment Board study, "Joint Ventures Among Health Care Providers In Florida," reinforces the Private Practice Section's concerns about the impact referral for profit has on the quality, cost and utilization of physical therapy services.

Florida Joint Venture Study

The Florida study examined ownership and referral arrangements ("joint ventures") among health care providers. Volume II of the report contains information on the prevalence of joint ventures and assesses their impact on access, utilization, costs, and quality of health care services provided by various types of facilities.

The study found joint-venture arrangements involving physical therapy/rehabilitation centers, along with clinical laboratories and diagnostic imaging centers, to be the most problematic of all arrangements surveyed. The Board concluded that joint venture physical therapy facilities have significantly higher utilization rates, charges-per-patient and profitability, but provided lower access to Medicare recipients and lower quality of care than nonjoint venture facilities.

The Florida study found that patients treated at physician-owned facilities specializing in physical therapy receive 43 percent more visits per patient than those treated at nonjoint venture centers. In addition, patients treated at physician-owned comprehensive rehabilitation facilities averaged 32 percent more physical therapy visits than patients treated at nonjoint venture facilities.

Increased utilization of services did not, however, translate into improved quality of services. Instead, the study found that joint venture physical therapy centers provide a lower quality of care, because workers either spend less time with each patient or because services are not administered by licensed practitioners.

According to the study, physician-owned physical therapy facilities provide an average of 62 percent more visits per full-time equivalent ("FTE") licensed physical therapist than nonjoint venture facilities. When therapist assistants are included, physician-owned physical therapy facilities provide about 40 percent more visits per worker than did other facilities. The findings were similar for rehabilitation facilities that provide physical therapy services: physician-owned rehabilitation facilities provide about 51 percent more visits per licensed physical therapist and therapist assistant than nonjoint venture facilities.

Need for Action

The Florida study dramatically illustrates the profound negative effects joint venture arrangements can have on access to affordable, high quality physical therapy care. At a time when our nation is struggling to rein in rising health care costs, we simply cannot afford to ignore financial arrangements that encourage overutilization of services, particularly when the quality of those physical therapy services are compromised by scheduling systems and personnel practices designed to enrich the physician-prescriber rather than to maximize the patient's rehabilitation potential.

Recognizing the potential for abuse that referral for profit arrangements pose, Congress in 1989 banned most physician referrals to clinical laboratories in which the physician has a financial interest. The Florida study indicates that the same problems exist with referral arrangements involving physical therapy services. In fact, this situation is exacerbated in the physical therapy field because in 24 states, a patient must be referred by a physician in order to obtain physical therapy treatment. The Florida study concludes that in states where treatment by a physical therapist requires referral by a physician, "joint ventures may create a captive referral system which inhibits competition by nonjoint venture providers."

The prevalence of referral for profit arrangements is also undermining the public's faith in our health care system. Health Subcommittee Chairman Pete Stark has stated that "physician ownership/referral arrangements represent an exploding virus which ultimately will erode the trust patients have traditionally placed in their physicians." That virus has already infected the delivery of physical therapy services in numerous settings in which physician financial involvement all-too-often taints the assessment of and clinical response to genuine patient needs.

Joint venture arrangements are not the only type of referral arrangements that present the potential for conflicts of interest. The growing practice of physicians employing physical therapists in the office of the referring physician also invites severe abuse. Like joint venture arrangements, a physician's provision of in-office physical therapy services through an in-house employee allows physicians to exploit a captive referral source, which unfairly discriminates against private-practicing physical therapists and invites overutilization. Furthermore, the Private Practice Section has received numerous reports of the seriously deficient quality of care often provided in these situations. For instance, PPS members report that physical therapy services performed in physicians' offices are often not being provided by licensed physical therapists. For these reasons, the Private Practice Section believes strongly that the systemic abuses infecting physician-related physical therapy care can only be cured by extending the ban on physician ownership and referrals to both the joint venture and the physician office/employment settings.

In closing, the Private Practice Section strongly supports a ban on physician referral for profit. Because in-office employment of physical therapists by physicians would not necessarily be covered under current proposals to restrict physician ownership arrangements, the Private Practice Section believes that Congress must expand the scope of its efforts and ban the employment of physical therapists in physicians' offices. We appreciate the opportunity to work with the Committee to end these abusive practices.

STATEMENT OF THE AMERICAN SOCIETY OF INTERNAL MEDICINE

Overview

The American Society of Internal Medicine (ASIM), representing over 25,000 physicians nationwide who are subspecialists in adult medical care, appreciates the opportunity to submit written comments for the record of the October 17, 1991 hearing of the Subcommittee on Health and the Subcommittee on Oversight, Committee on Ways and Means on physician ownership and self-referral practices.

Congress continues to express concern over potential abuses that may result from physician financial relationships with ancillary health care entities, such as clinical laboratories, pharmacies, imaging and rehabilitation centers. Not surprisingly, these concerns were intensified by the release of the findings of the Florida Health Care Cost Containment Board which studied the prevalence, scope and nature of joint ventures among health care providers, and the effect of such ventures on access, utilization, costs, charges and quality of health care services. The Florida study concluded that health care entities, such as imaging centers and laboratories, in which physicians had invested, had higher costs than businesses offering the same services but not owned by physicians. It is critical that policymakers exercise caution when considering the results of this study as a basis for additional policy affecting physician ownership arrangements. The Florida Health Care Cost Containment Board did not consider whether a particular service was medically necessary when looking at the differences in utilization rates between physician-owned entities and nonphysician-owned ventures. Other reports, similar to the Florida study, that fail to factor in the medical necessity of the services provided when making comparisons between the volume of services provided by physician-owned joint ventures and non-physician owned joint ventures are flawed, as well.

ASIM agrees with Congress that the public has the right to expect that physicians will place their patients' interest above any potential gain that might result from a physician's financial interest in a medical care facility and that appropriate actions should be taken if a physician engages in unethical behavior due to an ownership interest in an ancillary health care facility to which he or she makes a referral. ASIM continues to believe, however, that broad, blanket bans, such as the prohibition on physician referrals to clinical laboratories in which the physician has a financial interest, could severely affect access to needed services. Such bans often impede financial arrangements that do not compromise patient care but instead offer competitive advantages such as lower fees, better quality control, and increased access. For this reason, in 1989, ASIM supported the speedy implementation of the Medicare and Medicaid Patient and Program Protection Act of 1987 setting forth exceptions (i.e."safe harbors") to the federal anti-kickback statute. These "safe harbors", which were finally implemented this year, detail proposed business and payment practices between physicians and health care entities that would be permitted and not considered unethical or illegal. ASIM continues to believe that the establishment of federal standards governing acceptable financial arrangements is far preferable to broad, blanket bans, such as those imposed on "self-referrals" to clinical laboratories. The "safe harbors" are likely to significantly alter many existing arrangements between physicians and other health care entities thereby eliminating any abuses that may exist, while at the same time allowing certain beneficial and appropriate arrangements to exist.

In light of the fact that physician ownership of ancillary health care facilities continues to be a concern among policymakers and remains the subject of public scrutiny, ASIM has developed additional policies that are workable, effective, practical and well-considered to protect patients from unethical and abusive practices, while allowing physicians to continue to invest in facilities that may offer a higher or more accessible level of service compared to that offered by competing facilities. *ASIM recommends that the following actions be pursued: (1) more aggressive efforts by the medical profession to identify and discipline physicians who violate the professional codes of ethics governing self-referral; 2) restructuring of existing relationships to minimize potential conflicts of interest consistent with the recently released "safe harbor" regulations and the opinions of the Ethical and Judicial Affairs Council of the American Medical Association (AMA); (3) identifying and sanctioning unethical and abusive medical practices through the enforcement of the existing federal anti-kickback statute, and "safe harbor" regulations; (4) conducting additional studies on the relationship between physician ownership and utilization of services including an assessment of whether such ownership contributes to* ***inappropriate*** *patterns of use; (5) evaluating the need for further legislation after a reasonable period of time is allowed for monitoring and assessing the health care industry's response to the "safe harbor" rules and the AMA's increased emphasis on disciplining physicians who violate the profession's ethical standards; and (6) maintaining a role for ethical and legitimate physician ownership arrangements that contribute to the availability of an ancillary service, and the delivery of quality health care, particularly those that are integral and essential to a physician's practice (such as in-office x-ray and laboratory services).*

The Advantages of Physician-Owned Ancillary Health Care Services

It is not uncommon for internists in different medical practices, who practice in the same building, to pool financial resources to provide ancillary health care services including laboratory testing and x-ray services. For example, by being able to pool their resources, physicians are able to purchase the best and most accurate laboratory equipment, and to hire the best personnel possible, to operate the equipment and perform testing. In addition, by virtue of the laboratory being located in the same building as their practices, internists are able to offer services in a more timely and accessible manner than would be the case if only a commercial laboratory were available. The direct involvement of physicians in owning and overseeing operation of the laboratory allows them to assure that the quality of work done by the facility is of the highest standards. The broad prohibition enacted in 1989 banning physician referrals to laboratories in which the physician has a financial relationship will make it very difficult, if not impossible, for internists involved in these kind of arrangements to continue to provide laboratory testing as a part of their practice (note that these arrangements would probably not fall under the physician office laboratory or group practice laboratory exceptions of OBRA '89).

Typically these arrangements are referred to as "shared laboratories". In essence, the physicians involved each treat the "shared laboratory" as a physician office laboratory (POL). The laboratory is in close proximity (i.e. same building) to the practices of the physicians involved. In some cases, only two solo practice physicians may share the same office space allowing the laboratory to be located right in the office space of both physicians. ASIM would argue that these kind of shared laboratories are actually very cost-effective and provide increased access to laboratory services to patients. It seems illogical to require physicians in these kind of arrangements to each purchase their own laboratory equipment so as to meet the definition of a physician office laboratory and to qualify for an exception under the law. In actuality the shared laboratory already operates as a POL. These laboratory arrangements are designed only to enable physicians involved to perform testing on their own patients in the most cost-effective manner. In these cases, it is much more cost-effective for physicians to share the overhead costs of operating a single laboratory than each individual practice purchasing their own often expensive laboratory equipment.

ASIM has been working with the Health Care Financing Administration (HCFA) on the effect of the OBRA '89 self-referral prohibition on legitimate "shared laboratories." ASIM is aware that HCFA will be requesting comments, when the proposed rule implementing the prohibition is published, to find out how prevalent these arrangements are and recommendations on if and how this issue should be resolved. ASIM recognizes that some "shared laboratory" arrangements may not be legitimate and any regulations that are drafted to address this issue will have to be crafted in a workable and effective way so as to protect legitimate arrangements and not allow illegitimate arrangements to escape the intent of the law. ASIM is concerned that additional broad, blanket bans, such as the prohibition on "self-referrals" to clinical laboratory services, would, if enacted, have similar effects on those ancillary health care services to which the prohibition applies.

Analysis of the Florida Study

The Florida study on joint ventures among health care providers, released this August and conducted by the Florida Health Care Cost Containment Board, has attracted nationwide attention. The Florida Health Care Cost Containment Board concluded that clinics and laboratories in which physicians had invested had higher costs than businesses offering the same services but not owned by physicians. The study asserts that physician-owned joint ventures were used more frequently. ASIM believes the most obvious flaw in the report is its failure to take into account the fact that physicians, whose specialties demand certain diagnostic procedures, are more likely to invest in facilities that test for a particular procedure. In other words, physicians tend to invest in those facilities they are more likely to use in an effort to make such services easily available and accessible to their patients. A natural result is facilities owned primarily by those specialties that need such services for diagnosis of patient illnesses are likely to demonstrate higher utilization rates than those facilities owned by a more diverse group of investors. For example, internists are very likely to invest in laboratories because such tests are critical to the nature of their specialty. Internists are less likely to invest in imaging and mammography centers.

Like many other studies of this kind, and as admitted by the authors of the study, the Florida study fails to address the issue of appropriateness and necessity of care. The critical issue at hand is not one of physician ownership in joint ventures, but one of appropriate care and utilization of services and referral regardless of ownership. Other studies suffer from the same limitation. A December 1990 study published in the New England Journal of Medicine concluded that physicians who own their own diagnostic imaging equipment in their offices perform more radiography than those who refer their patients to radiologists. Like the Florida study, ASIM's major criticism of the report is that the study failed to provide a basis for determining whether the care provided by physicians who own their own equipment is appropriate. It is entirely possible that physicians who refer their patients to radiologists for testing might be underutilizing the services because referrals can be inconvenient for patients. It is critical that policymakers determine whether the care provided is medically necessary before any policy decisions are made based on such studies.

A recent independent analysis of the Florida study was conducted by Lewin/ICF. Lewin/ICF was asked to review the report and assess the validity of the study's conclusions with regard to MRI and CT scanners. Lewin/ICF concluded that the data in the report was flawed and inaccurate. Specifically, Lewin/ICF observed that the differences in utilization may reflect incorrect population data and regional variations in practice patterns. Lewin/ICF concluded that the data on utilization included in the report did not justify the conclusion that differences in utilization are due to different ownership patterns among diagnostic imaging centers.

Despite the imperfections of these studies, ASIM believes that such studies do present some evidence that a growing number of physicians may be unaware of the appropriate actions to take when a conflict of interest arises surrounding a self-referral.

ASIM Policy and Strategy on the Self-Referral Issue

The Society has continued to strongly support the 1989 opinion of the AMA Council on Ethical and Judicial Affairs, which states that "physicians should seek to avoid even the appearance of impropriety in medical decisions that even remotely are related to their financial interest". The Council's opinion provides voluntary guidelines for physicians that are designed to separate income generation from the volume of referrals or utilization to avoid any such appearance of impropriety. For example, physicians should disclose to patients that they have a financial relationship with the health care entity and, if possible, provide the patient with a list of alternative facilities from which the services can also be obtained. ASIM strongly supports the AMA's recent efforts to take a more aggressive approach to educating physicians of their ethical responsibilities regarding the self-referral issue and to actively investigate reports of abuse or non-compliance with the Council's opinion. ASIM believes that the following approaches to the self-referral issue should be pursued as an alternative to additional broad, blanket bans on physician referrals to health care facilities with which they have a financial relationship. These approaches offer a reasonable, constructive, practical and well-considered approach to protect patients from unethical and abusive practices, while allowing physicians to continue to invest in facilities that may offer a higher or more accessible level of service compared to that offered by competing facilities.

(1) The American Medical Association recently launched an aggressive campaign to raise physician awareness of the AMA's codes of ethics as it relates to self-referral and to develop state-by-state programs to actively investigate reports of abuse or non-compliance with the Council's opinion. ASIM *strongly* supports the AMA's efforts. The AMA guidelines state the following: (a) the physician has an affirmative ethical obligation to disclose to the patient or referring colleagues his or her ownership interest in the facility or therapy prior to utilization; (b) the physician may not exploit the patient in any way, as by inappropriate or unnecessary utilization; (c) the physician's activities must be in strict conformance with the law; (d) the patient should have the free choice either to use the physician's proprietary facility or therapy or to seek the needed medical services elsewhere; and (e) when a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient. The Council itself intends to solicit, review and/or refer to the appropriate professional association any complaint involving self-referral. Specifically, the Council intends to initiate three actions:

- A communication campaign to educate physicians about the ethics of self-referral. The primary components of the Council's opinion will be communicated in several ways through: a) an individual mailing to all members through AMA's Member Matters publication; b) a special bulletin in American Medical News; c) publication of the Council's guidelines in the Journal of the American Medical Association; and d) a special segment on American Medical Television.

- The Council is asking all state, county and specialty societies, through their grievance and discipline committee, to actively investigate reports of abuse or non-compliance with the Council's opinion, and the Council itself intends to solicit, review and/or refer to the appropriate professional association any complaint involving self-referral.

- The Council intends to appoint a special advisory panel to assist the Council in analyzing the need for additional guidelines for physicians. The panel will complete its work in early November to permit the Council to consider the panel's views in drafting a report to the AMA House of Delegates in December of this year. ASIM will be monitoring the Council's work and will develop additional policy in this area. The Society will share its work with this Committee once developed.

(2) As previously indicated, with the publication of the safe harbor rules, the regulatory environment has been dramatically altered. For example, prior to the publication of the rules, it had been unclear how health care facilities that are wholly-owned by physicians in a position to refer patients to them would be treated under the federal anti-kickback statute. Now, investments such as joint ventures and limited partnerships are protected *only*, if among other things, no more than 40 percent of the investors are in a position to refer patients or business, and only 40 percent of the business is generated or referred from investors (known as the "60-40" rule). This means that 60 percent of the revenues generated by a facility must not come from physician investors. Likewise the number of physicians, who will refer their patients, is limited to 40 percent. At least sixty percent of the investors must not be in a position to refer.

The studies that have been conducted, thus far, evaluating the utilization and access to ancillary health care services were conducted prior to this significant change in the regulatory framework under which these financial relationships between physicians and other health care facilities now must operate. These safe harbors will inevitably cause many facilities and physicians to re-structure their arrangements to fall under a "safe harbor". Others will change the nature of their arrangements on the advice of the Office of Inspector General to make a good faith effort to comply. Even for those that choose not to restructure their investments along the lines of a "safe harbor", the greater scrutiny, exposure and potential liability that they may incur by not seeking such protection will act as a compelling reason for them to avoid any actions that would create even a suspension of unethical behavior. Consequently, the "safe harbor" rules are likely to eliminate most or all arrangements that may have led to abuse and provides sufficient authority to the Inspector General to prosecute those physicians and others involved in an unethical and abusive arrangement. Studies performed a year or so from now are likely to come to very different conclusions regarding utilization of health care services in these arrangements and access to care.

In ASIM's view, it is logical and appropriate for Congress to continue to evaluate and study the effects of the "safe harbor" regulations on access to and utilization of ancillary services. If the restructuring that occurs because of the "safe harbor" regulations is effective in eliminating any abusive arrangements -- and it is demonstrated that the regulations give the Inspector General sufficient authority to sanction those individuals involved in abusive arrangements -- additional restrictions on referrals will not be necessary.

(3) Implementation of the self-referral ban for clinical laboratories provides an opportunity for Congress to evaluate whether or not an outright ban on physician ownership adversely affects access to quality laboratory testing. ASIM is concerned that should HCFA fail to provide, through regulation, some protection of appropriate and legitimate "shared laboratory" arrangements it is unlikely that physicians involved in these kind of practical arrangements will be able to afford to have their own laboratory. The implementation of the Clinical Laboratory Improvement Act of 1988 (CLIA '88), while desirable, is likely to compound the effects of the ban on access to laboratory services due to the increased costs associated with the quality assurance standards. In the face of increased costs of CLIA '88, it seems logical to exempt appropriate cost-effective "shared laboratories" from the prohibition. ASIM strongly urges Congress to evaluate the effects of the prohibition on access to laboratory testing before any decisions are made to extend the Stark prohibition to additional ancillary health care entities owned by physicians. Such evaluations should include a comparison of the effects of the Stark prohibition to the effects of the "safe harbor" regulations.

(4) Additional studies should be conducted to (1) evaluate the extent that physician ownership arrangements restructure in the next 12-18 months in response to the "safe harbor" regulations and the medical profession's emphasis on disciplining physicians who engage in unethical practices; and (2) the relationship, if any, between physician ownership and *inappropriate* utilization following such restructuring. The final "safe harbor" regulations require the Office of Inspector General to report to the Secretary of Health and Human Services on the extent that physicians and health care facilities involved in financial arrangements are complying with the "safe harbor" regulations. This study is

likely to provide some very useful preliminary data on the effects of the "safe harbors" on the restructuring of financial relationships. Additionally, OBRA' 89 required the General Accounting Office (GAO) to compare utilization rates of physician-owned and nonphysician-owned health care entities. HCFA is currently collecting data to conduct the study. It is important to point out, however, that the findings of this study may be limited since it will be an analysis of utilization of services prior to the implementation of the "safe harbor" rules and the AMA's increased efforts. It is highly questionable at this time whether additional restrictions on physician referrals to facilities with which they have a financial relationship are necessary. Rather, further study of the relationship between ownership and utilization is in order following the restructuring that is likely to occur in the next several months.

As previously indicated, many of the studies on physician facility ownership and utilization rates fail to include an analysis of the medically necessity of the services delivered yet conclude that physician ownership causes *inappropriate* utilization of services. ASIM believes that studies that fail to give credence and attention to whether or not services are necessary are largely driven by a goal to contain health care costs. While ASIM fully supports efforts to contain the rising costs of health care in this country, it is a mistake to discount and overlook the importance of ensuring the delivery of necessary, quality health care. It is important to look at other factors that may result in the disparity in utilization of services by physician-owned entities compared to nonphysician-owned entities. As previously discussed, for example, physicians tend to invest in those facilities they are more likely to use in an effort to make such services easily available and accessible to their patients. A natural result is facilities owned primarily by those specialties that need such services for diagnosis of patient illnesses are likely to demonstrate higher utilization rates than those facilities owned by a more diverse group of investors. Internists are very likely to invest in laboratories because laboratory services are such an integral part of the practice of internal medicine. Internist-owned laboratories are likely to have higher rates of utilization of services than laboratories owned by a more diverse group of investors. Future studies should specifically address the reasons that utilization patterns may differ between arrangements regardless of physician ownership, and the degree, if any, that such differences reflect higher rates of *inappropriate* utilization of services in entities that are partially or wholly-owned by physicians.

(5) Physician-owned services that are integral to a physician's practice should be fully protected. The availability of in-office laboratory and x-ray services, for example, are integral to the practice of internal medicine. Patients would be greatly inconvenienced and the timeliness and quality of diagnosis and treatment impaired if such services were prohibited. Congress should assign the highest priority to identifying, in consultation with the medical profession, those services within each specialty that are integral to their practices and therefore must be protected from misguided and overly broad enforcement of the anti-kickback statute.

Conclusion

ASIM believes that the public will be best served by attempting to reach middle ground that prohibits referrals to entities that expose patients to an unacceptably high degree of potential conflict of interest, while maintaining access to facilities that serve the public interest. It is unclear at this time what effect the Stark prohibition will have on closing legitimate laboratory arrangements. It is also unclear what effect the "safe harbor" regulations will have on restructuring financial relationships and eliminating abusive arrangements. Considering the existing regulatory environment, ASIM believes it would be very premature for Congress to extend the ban on physician referrals to laboratories in which they have an ownership interest in other health care facilities. ASIM urges Congress to delay additional legislative initiatives until the effects of these efforts can be properly assessed. ASIM is committed to working with Congress to develop additional, effective, strong and practical federal policy on referrals of patients to entities in which the physician has a financial interest, if necessary.

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WASHINGTON CONVENTION CENTER
WASHINGTON, D.C.

November 8, 1991

The Honorable Pete Stark
Chairman
Subcommittee on Health
Committee on Ways and Means
1114 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Stark:

The American Urological Association (AUA) submits the following comments on the issue of physician ownership and referral and requests that this letter be made a part of the formal hearing record of the October 17th hearing on this issue jointly conducted by the Subcommittee on Health and Subcommittee on Oversight.

AUA is keenly interested in the debate over the impact of physician ownership and referral arrangements on health care costs, quality and access. The issue arises most commonly in urology through ownership of extracorporeal shock wave lithotripsy (ESWL) units and ambulatory surgery centers. A number of urologists around the country have an ownership interest in lithotripsy centers where they provide services to their own patients with renal stone disease. The other more common ownership interest of urologists is in ambulatory surgery centers where they provide outpatient surgical services to their patients.

These ownership arrangements are now subject to the newly announced safe harbor rules. The rules will have a significant impact on the nature of these business arrangements, and AUA believes that many of the concerns raised by Congress about ownership and referral will be addressed through the action of the safe harbor rules. Therefore, we urge the Subcommittees to defer any legislative action until they have had an opportunity to evaluate the impact of "safe harbors".

Should Congress decide to proceed with legislation effecting physician ownership, either now or in the future, AUA believes that distinctions can, and should, be made between therapeutic and diagnostic settings. Therapeutic settings, such as the lithotripsy unit or the ambulatory surgery center, are subject to peer review and utilization review. The opportunity for fraudulent or abusive practices is extremely small. The physician/owner is also providing services to his or her own patients in these settings and the risks of abuse either to the program or to the patient are minimal.

AUA recognizes that the Committee has heard extensive testimony about abusive practices involving physician ownership and referral arrangements. This testimony certainly suggests that some remedial action may be required. We believe that the government can deal with the concerns that have been raised, particularly in some diagnostic settings, without outlawing all physician investment in health care facilities. Therefore, we recommend any future legislative action not affect these types of arrangements. In fact, the term referral is not appropriate for the circumstance in which the physician owner is also providing the service.

AUA recognizes that there have been abuses in some physician ownership and referral arrangements. We believe the federal government should take steps to limit the opportunity for this abuse. This can be done without outlawing all physician ownership and referral arrangements. We particularly believe that the therapeutic settings, such as ambulatory surgery centers and lithotripsy units, where the physician is providing services directly to his or her own patients should be exempt from this legislation.

AUA appreciates the opportunity to submit these comments to the Subcommittees.

Sincerely,

Jay Y. Gillenwater, M.D.
President

NAMES
National Association of
Medical Equipment Suppliers

STATEMENT

OF

CORRINE PARVER

PRESIDENT

NATIONAL ASSOCIATION OF MEDICAL EQUIPMENT SUPPLIERS

ON

PHYSICIAN OWNERSHIP/REFERRAL ARRANGEMENTS

FOR THE RECORD

OF

THE HOUSE WAYS & MEANS COMMITTEE
HEALTH AND OVERSIGHT SUBCOMMITTEES JOINT HEARING OF

OCTOBER 17, 1991

I am pleased to submit this statement on behalf of the National Association of Medical Equipment Suppliers (NAMES). NAMES represents a diversified membership of 2,100 home medical equipment (HME) suppliers operating in 4,500 facilities nationwide, over 100 HME manufacturers and 38 state and regional HME associations. NAMES is the only national trade association representing the HME industry exclusively.

Based upon individual patient needs and only according to physicians' prescriptions, our members furnish a wide variety of equipment, supplies and services for home use. These items may range from traditional medical equipment such as hospital beds, to highly sophisticated items and services such as intravenous chemotherapy; parenteral and enteral nutrition for individuals who cannot eat normally; apnea monitors, which allow parents to closely guard high-risk infants' breathing; and wheelchairs and other technologically-advanced equipment, which are individually customized to meet the needs of people with permanent and profound disabilities. A substantial portion of HME clients are Medicare and Medicaid beneficiaries.

It is important to remember that home medical equipment and services comprise a vital and very cost-effective component of our nation's home health care system. HME products and services help elderly and disabled individuals be discharged earlier from more costly hospitals or other institutions with appropriate medical equipment available to assist them at home. It is also the HME industry which enables quadriplegics, paraplegics and other people with severe disabilities to lead productive lives in the mainstream of society.

NAMES strongly supports Congress' efforts to eliminate unethical practices in the HME industry. We have a common interest: to rid the HME industry of those few unscrupulous suppliers who have tarnished the reputation of an otherwise valuable industry.

Equally important as ridding the HME industry of unscrupulous suppliers is the desire by NAMES to help eliminate abusive practices within the Medicare program which impact the HME industry. For this reason, NAMES supports the efforts of this Committee to study closely the issue of linkage between physician facility ownership and utilization rates. NAMES believes that physician self-referral to ancillary medical facilities -- including HME -- may result in overutilization and excess costs to the Medicare program through the obvious economic incentive to the physician "self-dealer". Additionally, non-physician owned HME facilities may find themselves at a severe competitive disadvantage in the marketplace, regardless of the high-quality of care and service provided by such facility.

On June 4, 1991, Representative Ben Cardin (D-MD) introduced the "Ethics and Treatment of Home Medical Equipment Act of 1991", H.R. 2534. This unprecedented legislation would close loopholes in current Medicare law which have led to questionable practices in some cases. In particular, the bill, if enacted, would extend the current prohibition of physician self-referral to clinical laboratories to HME. By imposing this measure of needed quality control on the provision of HME products and services, NAMES hopes to help eliminate the incentive to overcharge and/or over-prescribe items of HME, thereby lowering the nation's health care bills.

Additionally, H.R. 2534 would help ensure that all HME suppliers meet the high standards that the overwhelming majority of them do already, by requiring adherence to strict standards of practice under the Medicare program. As well, the legislation would encourage accreditation of HME suppliers and, unlike what occurs today, would bar participation in Medicare for non-certified suppliers.

This strong legislation addresses explicitly the problem of unethical practices in the HME industry and abusive practices in the overall Medicare program. H.R. 2534 would allow only those HME suppliers who meet certain minimal standards established by the Department of Health and Human Services to provide services under the Medicare program. Currently, the HME industry is one of the very few major health care provider categories that is not subject to any type of governmentally required standards of practice, health and safety.

Such standards would include: establishing patients' rights and responsibilities; requiring the notification of patients of their rights and responsibilities; and addressing patient care, safety management and infection control, quality assurance, administration, clinical services (where applicable) and equipment management.

In summary, NAMES joins in the Ways & Means Committee's concerns of working to eliminate unethical and abusive business practices in the Medicare program. The HME industry is a valuable, increasingly vital element in our nation's health care system. This industry truly helps make homecomings possible. In an era of increasing cost-consciousness and concern about the long-term care of our nation's elderly and people with disabilities, it makes plain policy sense to preserve the very benefit that provides home health care services in the most cost-effective and yet compassionate fashion. But it is likewise a policy necessity to fashion educational and legislative safeguards against those who would abuse Medicare and its beneficiaries.

Instances of fraud and abuse perpetrated on unsuspecting beneficiaries must be eliminated. To do this requires a combined effort on the part of industry, Congress, the Administration and beneficiaries. We are committed to help ensure that all member companies act ethically. We will continue to take the lead in addressing unethical practices through education, cooperation with OIG and HCFA and, hopefully with your help and support, through passage of H.R. 2534.

STATEMENT OF ROBERT ZIGENFUS, ON BEHALF OF THE NATIONAL ASSOCIATION OF REHABILITATION AGENCIES

Introduction

On behalf of the National Association of Rehabilitation Agencies (NARA), I am pleased to present this testimony on the subject of physician referral practices. NARA is an association representing approximately 150 Medicare-certified rehabilitation agencies which provide physical therapy, speech pathology, occupational therapy, and social and vocational adjustment services to Medicare beneficiaries. Many NARA members also provide care to beneficiaries under Medicaid and other state health programs.

For years, NARA has been strongly supportive of legislative and regulatory efforts to eliminate fraud and abuse from the Medicare and Medicaid programs. In 1987, NARA supported passage of the Medicare and Medicaid Patient and Program Protection Act. In 1989, when the Health and Human Services' Office of Inspector General (OIG) published proposed "safe harbor" regulations identifying those business arrangements and referral practices which would not be prohibited under the anti-fraud law, NARA filed extensive comments on the proposed rule. NARA offered several recommendations for strengthening the safe harbor regulations including, inter alia, closing the loophole in the bona fide employee exemption which permits physicians to employ health care professionals and make referrals to them. In 1989, NARA also endorsed Chairman Stark's efforts to curb abuse in the Medicare program through passage of the Ethics in Patient Referrals Act. In June of that year, when this Subcommittee conducted hearings on that legislation, NARA testified in support of Chairman Stark's bill and urged that it be amended to close the bona fide employee loophole.

Our organization will continue to support efforts on the part of this Subcommittee to close those gaps in the current laws which permit physicians to abuse patients and defraud the health care delivery system. We firmly believe that such gaps exist, especially with regard to: (1) joint ventures, and (2) the employment of health care professionals to whom the employing physician makes referrals. There is a direct and pernicious inter-relationship between these two "problem areas" which, unfortunately, has been overlooked in the past. NARA strongly suggests that any renewed efforts to address the former with its obvious potential for abuse must include reform of the latter, the "back door method" of accomplishing the same type of referral abuse. Otherwise, physicians will exploit this employment exemption, reducing it to a "Plan B" for perpetuating abusive referral schemes.

Joint Ventures

In 1977, after several state commissions and legislative investigative committees and the United States General Accounting Office focused attention on the service and billing patterns in clinical laboratories with physician owners, Congress passed the first reform legislation to address kick-backs and other inappropriate remuneration schemes which it believed were defrauding the Medicare and Medicaid programs -- the Medicare-Medicaid Anti-Fraud and Abuse Amendments. Congress recognized that when a referring physician has an ownership interest in another provider, there is a great potential for abuse. For that reason, the legislation required providers to disclose fully those persons having direct or indirect ownership interests in their businesses.

In 1987 and 1989, Congress made further efforts to strengthen the rules so that "referral for profit" to physician-owned entities might be eliminated. The Medicare and Medicaid Patient and Program Protection Act and the Ethics in Patient Referrals Act stiffened the penalties for fraud in this area, but did not completely bar investments by physicians in most health care entities. The "safe harbor" regulations issued by the HHS OIG pursuant to passage of the 1987 law reflect the position taken by the Congress at that time -- viz. available data did not justify outright prohibition of joint ventures and therefore, physicians should be allowed to have ownership interests in other providers so long as those interests were not fraudulent or abusive.

In 1991, however, very compelling data is available which evidences the extent of physician investment in other providers and the pernicious effect this has on referral practices. In 1989, the OIG carefully studied this issue and concluded that joint ventures result in over-utilization and higher costs. Subsequently, the OIG issued a Fraud Alert to Medicare and Medicaid providers, describing various suspect features of these business relationships.

Two months ago, the State of Florida Health Care Cost Containment Board in conjunction with the Department of Economics and the Department of Finance of Florida State University published a study of the prevalence, scope, and nature of joint ventures among health care providers in Florida. The report also evaluated the impact of joint ventures on access, utilization, costs, charges and quality of health care services in Florida. The Florida Report found convincing evidence that joint ventures increase opportunities for self-dealing, create the impetus for over-utilization and contribute to higher health care costs.

NARA believes that the time has come to prohibit physician joint venture arrangements. Now, as more and more Americans are unable to obtain health care because of skyrocketing prices, Congress should take decisive action to combat this practice, which all data plainly indicates is a direct cause of higher costs.

To effectively prevent abuse, Congress must enact legislation which not only prohibits joint ventures, but also prohibits the employment of health care professionals to whom referrals are made. Otherwise, such employment will become "the alternative to the joint venture" for those physicians intent on abusing the system.

Employment of Health Care Professionals to Whom Referrals are Made

From the beginning of its efforts in 1977 to protect against fraud and abuse in the Medicare and Medicaid programs, Congress made it clear that the anti-kickback legislation is not meant to prohibit payments made by an employer to an employee with a bona fide employment relationship in the provision of covered services. The OIG described this exemption in its proposed safe harbor rule in 1989:

> This statutory exemption permits an employer to pay an employee in whatever manner he or she chooses for having that employee assist in the solicitation of Medicare or State health care program business. The proposed exemption follows that statute in that it applies only to bona fide employee-employer relationships....
>
> In response to the October 21, 1987 request for comments, many commenters suggested that we broaden the exemption to apply to independent contractors paid on a commission basis. We have declined to adopt this approach because we are aware of many examples of abusive practices by sales personnel who are paid as independent contractors and who are not under appropriate supervision. We believe that if individuals and entities desire to pay a salesperson on the basis of the amount of business they generate, then to be exempt from civil or criminal prosecution, they should make these salespersons employees where they can and should exert appropriate supervision for the individual's acts.

54 F.R. 3088, 3093. (Emphasis added.)

Unfortunately, some physicians have exploited the employee exemption to protect arrangements whereby they employ physical therapists, speech pathologists, occupational therapists and other providers of care so that they will directly benefit from referrals which they make to these employees. When physicians employ therapists to provide services pursuant to their own referrals, there is the same increased opportunity for self-dealing and abuse of the Medicare and Medicaid programs as exists in joint venture situations -- perhaps more.

A patient referred to a therapist employed by the referring physician is, as a practical matter, cut off from any other choice -- the choice of a therapist better suited to his needs or the choice of a therapist with whom the patient may already be comfortable and familiar. The patient may even be forced in this situation, against better medical judgment, to interrupt a program of therapy with another therapist. Medicare and Medicaid patients, because they must have a physician's referral in order to have the expense reimbursed, are often "trapped" into using the physician's own therapist.

In commenting upon the safe harbor for employees as proposed by the OIG in 1989, NARA described the potential for abuse under the employee exemption. The OIG responded that because the exemption for bona fide employment relationships was "clear on the face of the statute", HHS was not at liberty to address the situation through regulation. NARA respectfully requests that as this Subcommittee proceeds with its study of abusive referral practices, it should consider legislation to fine-tune the employee exemption so that the exemption accomplishes its goal but does not provide an open invitation to fraud and abuse.

NARA supports legislation to eliminate situations in which physicians may have an incentive to make treatment decisions for their patients based on anything other than the best interests of the patients. Joint ventures which create conflicts of interest outside the doctor's office and physician employment of providers which creates conflicts of interest inside the doctor's office must therefore be proscribed.

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Statement of the Renal Physicians Association to the Ways and Means Subcommittees on Health and Oversight

Re: Physician Ownership/Referral Arrangements
For the Hearing Record, October 17, 1991

The Renal Physicians Association (RPA) appreciates this opportunity to present to the Ways and Means Subcommittees on Health and Oversight a statement for the record of the October 17, 1991 hearing on physician ownership/referral arrangements.

RPA is a national medical specialty organization, representing over 1700 nephrologists. Our organization is committed to ensuring optimum care under the highest ethical standards of medical practice for patients with renal disease and related disorders.

RPA shares the Subcommittees' concerns regarding abusive and unethical medical practices by physicians, and supports appropriate efforts to eliminate such arrangements. As nephrologists who treat Medicare patients under the End-Stage Renal Disease (ESRD) program, however, we are uneasy about a potential outright ban on referrals to any facility in which the physician has an ownership interest -- a concept which Chairman Stark has advocated in the past. Many of our members own dialysis facilities, and for a variety of reasons, as discussed below, we believe that physician ownership and referral to these facilities should continue unimpeded.

When Chairman Stark first introduced the Ethics in Patient Referrals Act of 1989, which banned physician ownership and referral to most entities and for most arrangements, free-standing and hospital based renal dialysis facilities were not provided with a specific exemption under the bill. Yet, in the months that followed, Chairman Stark agreed that such an exemption was appropriate given the unique nature of dialysis, and the relationship between the nephrologist, the patient, and the dialysis facility. RPA was pleased to work with Chairman Stark to craft legislative language to make that position very clear. Although the need for such an exemption never came to pass, as the bill became one which only banned ownership and referral to clinical laboratories (with some exceptions), we hope our agreement with Mr. Stark as to why nephrologist-owned dialysis facilities need to maintain their existence remains the same. But, for purposes of discussion, and to hit home this need once again, we will recount the principle arguments as follows:

Dialysis as an Extension of Practice

Dialysis services are integral to, and a central part of, a nephrologist's practice. In essence, dialysis services are an extension of a nephrologist's practice.

No Potential for Abuse

Dialysis facilities do not provide opportunities for abuse because: (a) there is no opportunity to artificially inflate prices as reimbursement is capped under the composite rate within the ESRD program -- it is a set prospective charge per treatment similar to DRGs; and (b) because overutilization is precluded -- nephrologists cannot create unnecessary utilization of services. Outpatient dialysis facilities serve only patients with irreversible kidney failure who must receive regular dialysis to maintain their lives. Dialysis is not an elective procedure for ESRD patients, and its medical necessity cannot be questioned. Most ESRD patients require dialysis three times per week in a facility (subject to hospital stays), and Medicare will rarely cover treatments provided with any greater frequency. Therefore, there is virtually no opportunity for the overutilization of services by dialysis facilities.

Highest Quality Care Delivered

Nephrologist-owned dialysis facilities promote optimal, quality care because they are in the hands of those with the most expertise to operate them, and because there is a built in incentive to promote quality of care. There are also existing checks through the activities of the ESRD network organizations to ensure that the care received in dialysis facilities is of high quality.

Patients' Free Choice Maintained

Although we are not aware of any problems with regard to patient free choice in pursuing dialysis services at other facilities or other modalities of treatment if medically indicated, we are sensitive to any potential for abuse. We understand that Chairman Stark is collecting and analyzing data by state comparing rates of different treatments including transplantation, home, and in-facility dialysis. RPA would be pleased to assist in interpreting that data.

An extremely careful evaluation would need to be conducted on the issue of physician owned dialysis facilities before it would be prudent for Congress to want to change existing arrangements, especially given the magnitude that such changes would foster. A prohibition of nephrologist-ownership of dialysis facilities would have a disastrous impact on the industry, creating chaos, and unfairly destroying the economic value of physician-owned dialysis facilities. It could also cause serious problems with access to dialysis for ESRD patients, particularly in the short-term.

Therefore, should there be a need for another bill broadly banning referrals to physician owned entities, RPA suggests that the following legislative language (which we understand would have been included in the original 1989 bill) be adopted to exempt free-standing and hospital based dialysis facilities who provide in-center as well as home dialysis services:

> A referral by a physician to a renal dialysis provider in conjunction with a renal dialysis procedure performed under the direction of the physician does not constitute a "referral" by a "referring" physician.

Since it appears that definitions and additional exceptions relating to nephrologist-owned dialysis facilities will likely be necessary to ensure that such facilities are completed protected under the law, the RPA looks forward to working with Members and theirs staffs to craft these details.

No statement on self referral would be complete at this time without mention of the recently promulgated safe harbor rules. In this regard, the RPA continues to work with the Office of the Inspector General (OIG) so that they will, like Congressman Stark has in the past, understand the unique nature of dialysis and the relationship between dialysis centers and their nephrologist owners. We understand that the OIG is working on additional safe harbor regulations (expected to be published in proposed form by year-end) that will protect payments for services provided as an "extension of (the physician's office) practice." Dialysis services provided by nephrologists at their own facilities are an ideal example of what it means when a service/facility is simply an "extension of (one's own) practice." That is, when a nephrologist; sees a patient in his or her office and makes a referral to a dialysis facility in which the physician has an ownership interest, such a referral is simply not a referral, but a service provided as an "extension of practice." it is our hope that the OIG will define an "extension of practice" as a category of business practice that will be given safe harbor protection, and that physician owned dialysis facilities will fall under such a definition.

The Renal Physicians Association is pleased to be able to provide this statement, and will continue to work with Chairman Stark, the Subcommittees, and the Congress to ensure that ESRD patients are provided with medical care of the highest standards, both clinically and ethically.

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